

2005

The lived experience of new graduate baccalaureate-prepared Registered Nurses working in an acute care hospital setting

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THE LIVED EXPERIENCE OF NEW GRADUATE BACCALAUREATE-PREPARED
REGISTERED NURSES WORKING IN AN ACUTE CARE HOSPITAL SETTING

A Dissertation

Submitted to the Graduate Faculty of the
Louisiana State University and
Agricultural and Mechanical College
in partial fulfillment of the
requirements for the degree of
Doctor of Philosophy

in

The School of Human Resource Education
and Workforce Development

by

Jeannie Ricks Harper
B. S. Southeastern Louisiana University, 1985
M. S. N. Southeastern Louisiana University, 1994
December 2005

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ACKNOWLEDGEMENTS

As I embarked on this journey five years ago, it was apparent that it would require dedication and hard work. However, what I had not counted on was the phenomenal role that my professors, friends, co-workers, and family would play. Although there is no way to truly express my most sincere gratitude to all of them, I would like to take this opportunity to acknowledge their contributions to this dissertation.

To my wonderful friend, Mary Burke, who has gone through this process with me. Mary, who would have thought that we would have made it to this point? I never could have done this without you, and I want you to know that I am eternally grateful for your friendship and support. Also, thanks for the stats help! To my friends and co-workers, Ken Tillman, Kristin Whitty, Cathy Cormier, and Catherine Fontenot. Each of you has been there before, during and after classes. I wish each of you the best as you complete your research. I would be remiss if I failed to acknowledge Denise Hart and Sharon Landry, part of the Cruise Krewe, who has been much more than my co-workers; you've been my friends and cheerleaders. I want to thank you both for going the extra mile when I had to be working on my courses or dissertation. Also, I would like to express a special thanks to Courtney Michelli, for always being there and for being a wonderful addition to our little family. You're going to be a terrific nurse, and it has been a privilege getting to know you.

I would also like to recognize my committee, who expertly guided me through the research process. To my major professor, Dr. Krisanna Machtmes, who recognized my passion for qualitative research, and allowed me to conduct a study that was near and dear to my heart. Dr. Machtmes, your expertise and knowledge of research were

invaluable, and I am truly grateful for your commitment and guidance. Dr. Michael Burnett, thank you so much for sharing your expertise of research. I have learned so much from you, and I will always use the knowledge that I have gained as both a Registered Nurse and teacher. To Dr. Earl Johnson, your editorial contributions were invaluable and appreciated. I am so thankful that you agreed to serve on my committee, and your commitment to students is apparent. I would also like to thank Dr. Gerry Johnson, who provided insight and valuable input to my research. I appreciate your knowledge and dedication to adult education. Also, to Dr. James Moore, whose health care management background provided essential insight into my research. I am grateful that you were open to my qualitative study.

To my husband, Hal, thank you so much for supporting me throughout this endeavor. You never once complained, even though I was required to spend hours away on course work and research. You're my best friend, and I love you. To my children, Bryan and Rachel, I am so proud of both of you. I know that you'll both be successful in whatever you choose to do, and I love you both with all of my heart. Being your Mom has made me a better person. No matter what I have learned in all of my years in education, I learn more from both of you. God bless you! Also, to Margaret Harper, my mother-in-law, a very warm and special thanks for all of the love and support throughout the years. Let's cook a great meal soon!

I would also like to acknowledge the RNs who participated in my study. Your honesty, integrity, and commitment to nursing and your patients will be forever remembered. I appreciate each of you, and I know that the nursing profession is better because you're a part of it. You can take care of my family or me anytime!

I would like to dedicate this dissertation to my parents, Joe and Esther Ricks. For as long as I can remember, you instilled the importance of education in all of us. My commitment to higher education is primarily because of your influence. I really was listening, and I appreciate the sacrifices you made to ensure that we were educated. Mom and Dad, this is for you! I love you both!

Finally, my thanks to God for providing me with exceptional family and friends who are both supportive and unselfish. I know that it is through Him that this and all things are possible. Thanks be to God for blessing me with a wonderful support system and the wisdom to make what is hopefully the right decisions. Even when I had to learn the hard way, God helped to lead me in the right direction. I've learned to be a really good listener!

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ABSTRACT

The purpose of this study was to explore the lived experience of new graduate baccalaureate-prepared Registered Nurses (RNs) who work in an acute care hospital setting. The study was a phenomenological qualitative research design, with researcher-developed guiding questions to help direct the interviews. Participants had passed the National Council for Licensure Examination for Registered Nurses (NCLEX-RN), and had been practicing from three months to one year.

Eight RNs participated in the study, with seven usable interviews. Results found that new graduate RNs experience multiple stressors as they acclimate to their new roles. The primary stressors that were identified by the participants included high nurse-to-patient ratios, short orientation periods, time management and prioritizing, and lack of time with their preceptors. In addition, the RNs expressed frustration with the inability to spend quality time with their patients. They felt that although the patient's needs were met, they were rushed in providing care and were unable to serve as a patient advocate.

Other stressors identified by the RNs were concerns about interacting with physicians, and constant apprehension that a patient's condition would deteriorate and they would not recognize the change in a timely manner. In addition, concerns about lack of staff support were mentioned by a majority of the participants, and they were very particular whom they approached for assistance.

The results of this study also indicated that the new RNs were very committed to patient care and overall enjoyed nursing. While they acknowledged the stressors, many were very surprised by the mental and physical demands of working in an acute care

hospital setting. Preceptors were of great value in the transition, and served as a role model, educator, and support system.

The researcher identified the following themes that emerged: 1) The Honeymoon Phase, where the new RNs were excited, nervous, and anxious about beginning their job; 2) The Transition Phase, where reality of their roles began to set in, and multiple stressors were identified; and 3) The Divorce or Reconciliation Phase, where the new RN made the decision to stay or leave their job in the acute care hospital setting.

CHAPTER 1

INTRODUCTION

Change within health care systems in the United States is an on-going reality. Managed care and hospital downsizing have played significant roles in recent changes in health care delivery. As a result, patient acuity rates in the hospital have increased dramatically. In order to safely and adequately meet patient's needs, Registered Nurses (RNs) are needed to assist with health care delivery at all levels. Specifically, the need for RNs to practice in acute-care hospital settings is tremendous, where extremely ill patients require excellent bedside nursing care. Population growth and an aging society, coupled with increases in technology assist in maintaining longer life spans (Owens et al., 2001). Accompanying these longer lives will be acute and chronic disease processes that will require the education and knowledge base of an RN at the patient's bedside. Hospital admissions have been rising since 1995, and these older and significantly ill patients have increased the demand for nursing. There are very few, if any, adequate substitutes for RNs, and hospitals have not been able to meet rising demand by shifting some of the work onto unlicensed, lower paid non-RNs (Buerhaus, 2002).

Many of these changes in health care have led to numerous experienced nurses leaving the profession, and fewer students declaring nursing as a major (Buerhaus, 2002). This critical shortage of RNs is becoming a harsh reality throughout the country. The United States Bureau of Labor Statistics indicated that the need for nurses will increase 22% between 1998 and 2008 (Owens et

al., 2001). Similarly, the American Hospital Association reported that there were 126,000 unfilled full-time RN positions in United States hospitals (Buerhaus, 2002). Concurrently, the American Association of Colleges in Nursing (AACN) reported a decline in nursing baccalaureate program enrollments by 5.5% in 1998 (Owens et al., 2001). According to the Louisiana State Board of Nursing (LSBN), the majority of RNs in Louisiana are employed in acute-care hospital settings. Likewise, the majority of new graduates from baccalaureate nursing programs in Louisiana seek employment in the acute-care setting (Louisiana State Board of Nursing, 2002). Despite the large numbers of RN's employed in acute-care hospital settings, some organizations report an annual RN turnover rate of 40%. Furthermore, it is estimated that 40-50% of all new graduate nurses leave the acute-care facility within a year (Domrose, 2002). The cost of turnover can climb to 150% of the employer's annual compensation (Contino, 2002).

The nursing profession has been plagued by high turnover rates in employment for many years. Increases in technology, paperwork, and patient acuity have made it more difficult for even the experienced RN to provide safe and efficient patient care (Contino, 2002). However, increases in patient acuity, cost of orientation, and maintaining accrediting body compliance validate the need for RNs to practice long-term in acute care hospital settings. These changes in acute care hospital nursing prove challenging for the experienced RN; however, the realities of nursing practice that greet the new graduate nurse are especially overwhelming. New graduate nurses must learn to reconcile the

idealistic expectations held during nursing school with the rigorous challenges of contemporary practice (Yoder, 1995).

Once a new graduate nurse is employed in an acute-care hospital setting, many challenges confront both the new nurse and the facility. New nurse recruitment may take as long as three months, and another six months for the newly hired nurse to be able to function independently. Furthermore, it is estimated that the cost to replace a nurse could be as much as \$30,000. The intense investment into the hiring of a new graduate nurse is tremendous; therefore, every possible effort should be made to retain them (Winter-Collins and McDaniel, 2000).

According to Fisher, Hinson, and Deets (1994), RN turnover may represent the single most serious human resource issue in the health care industry today. The literature has shown that job stress is a factor that can lead to decreased job satisfaction and consequently the resignation of the nurse (Winter-Collins and McDaniel, 2000). Work stressors and extremely high expectations of new graduate nurses are contributing factors to the high attrition rate during the first year of employment (Owens et al., 2001). However, the literature is limited in identifying other stressors that lead to the resignation of the new graduate RN from acute-care hospital settings within the first year of employment. Identifying concerns and stressors before overwhelming the new RN could ultimately assist hospitals in decreasing high levels of turnover.

Problem Statement

The primary purpose of the study was to explore the lived experience of new graduate RNs working in an acute care hospital setting within the first year of practice as perceived by recent graduates of baccalaureate nursing programs employed in an acute care hospital setting in Louisiana.

Definitions of Terms

For purposes of the study, the following terms will be operationally defined:

New Graduate Registered Nurse. Registered Nurses who have graduated from a baccalaureate nursing program and are practicing within their first year of graduation.

Acute-Care Hospital Setting. A hospital in Louisiana which provides care for individuals, adult or children, who are acutely ill or require immediate hospital care. These units are not considered specialty units, such as an Intensive Care Unit or Labor and Delivery, and the nurse to patient ratio is usually higher (Venes, 2001).

Stressors. Any situation which is perceived as taxing or exceeding an individual's resources and endangering an individual's well-being while practicing as a new graduate RN.

Retention. The ability of the acute-care hospital to maintain the new graduate RN as an employee for greater than a one-year period.

Telemetry Unit. Clinical unit that has the capability to monitor cardiac patients continuously; the transmission of data electronically to a distant location (Venes, 2001).

Limitations

1. Measurement of stressors at one particular moment in time may not be an accurate representation of the stressors that new graduate baccalaureate nurses endure at all times in practice.

Significance of the Study

The need for new graduate nurses to remain employed in the acute-care hospital setting is tremendous. The nursing shortage coupled with the population growth and an aging society further validate the need for new graduate nurses to remain employed and gain experience in acute-care hospital settings. Rapid turnover of nurses results in constant staff shortages, and often leaves experienced nurses frustrated and stressed, thus unable to mentor the new graduate nurse appropriately. The experienced RNs simply do not have the extra time required to provide the guidance and support for the new graduate RNs, which is essential in assisting the new graduate RN in acclimating to their new role (Winter-Collins and McDaniel, 2000). Information gained from this study could generate a heightened awareness of the level of stress caused by selected professional, personal, and organizational factors. Identifying the stressors experienced by new graduate nurses could assist nurse and hospital managers to develop new strategies to retain new graduate and experienced nurses. Determining the main source of stress could provide information to schools of

nursing to generate curricular changes to better prepare nurses for the realities of practice in the acute care hospital setting. In addition, findings from this study could provide information to hospital education and staff development departments to develop programs that might assist all RNs in dealing with stressors, thus decreasing high levels of turnover.

CHAPTER 2

REVIEW OF THE LITERATURE

This chapter presents the literature pertaining to job stressors, satisfaction, and retention of new graduate baccalaureate Registered Nurses (RNs) who work in the acute-care hospital setting. In order to thoroughly examine the complex issues of new graduate RNs, the literature was searched from 1985 to present.

Job Stressors

The literature is limited in the identification of a variety of job stressors among new graduate baccalaureate nurses. A longitudinal study conducted by Brown and Edelman (1999) did not specifically target new graduate nurses. Instead, the study sought to identify initially perceived stressors and coping resources, and to compare these with actually reported stressors and available resources. The target population was both students and qualified new graduate nurses who were presently or had recently completed the Project 2000 course in the United Kingdom. The purpose of this course was to prepare students for clinical practice in the hospital and community settings as they enter the 21st century. Project 2000 also sought to move students away from schools of nursing into higher education. Students therefore had full student status instead of an apprenticeship, and were required to achieve higher academic attainment than had been previously required. This project was similar to higher education nursing programs in the United States, where students are required to achieve

higher academic achievement and are college-based rather than an apprenticeship experience.

The data was collected from three groups of nurses on two occasions separated by a six-month interval. Group one consisted of 73 students who had just commenced the course, group two included 20 students who had completed 18 months and were about to start their clinical experience for the Adult Branch in two of four Nation Health Service (NHS) Trusts, and group three was composed of 16 students who had just completed the course in the same two Trusts. All three groups agreed to take part in the study and complete a series of questionnaires. Six months later the same participants were asked to complete a series of follow-up assessments. Seventy-five percent of group one, 90% of group two and 93% of group three agreed to take part in phase two of the study.

During phase one, participants responded to a biographical stressor and support questionnaire designed specifically for the study. The study did not indicate if the questionnaire was researcher-developed. Open-ended questions were used to related potential stressors, resources and support. Group one and two participants were asked to describe in the questionnaire what they anticipated would be difficult during the first and fourth semester, which was a six-month period. These questions related to college, college work and clinical work. Group three participants were asked to describe what they thought would be difficult during the first six months of their professional career. In addition, all participants were asked to identify a range of factors that might present difficulties and to indicate “what” or “who” they thought might help if they

experienced any of the stated difficulties. Researchers made a transcript of the participants' descriptors and used Hutchinson's (1986) approach to grounded theory analysis to develop a coding system. The open-ended questions are described well in the study, as well as the themes which evolved by the responses.

The second phase of the study was conducted six months later, and participants were given a structured questionnaire with the three groups of stressor and support categories derived from phase one. Participants were asked to identify stressors that they felt they had actually experienced, and what and who was helpful when difficulties had been experienced in the previous six months.

Response rates from groups two and three were satisfactory; however, only 75% of group one responded. The study found that the primary potential stressor reported by group one was being able to feel competent to demonstrate theoretical knowledge. Group two reported the main potential difficulty as being able to maintain a balance between clinical work and studying and to feel competent in clinical skills. The primary anticipated difficulty for group three was meeting personal expectations of the role. In phase two all groups reported less difficulty than they had predicted. More individuals in groups one and two reported financial difficulties, although they had not anticipated this to be the case. Group three reported that meeting expectations of the role and feeling part of a peer group were not as difficult as they had anticipated. All groups reported using more resources than they had predicted. The researchers recommended

further studies to identify the nature of support required during the transition from student to staff nurse and how this might be delivered. In addition, the researchers recommended evaluating longer term effects on newly qualified nurses with regard to stress and coping.

A study conducted by Hinds et al. (1998), sought to test the stress-response sequence model in pediatric oncology nursing. Although this study does not target new graduate registered nurses, it does focus on nurses practicing in an acute-care hospital setting. The researchers acknowledged that the causes and intensity of role-related stress experienced by pediatric oncology nurses, the nurses' ability to respond to the stressors, and the professional and personal consequences of those stressors for the nurses are of concern for administrators and staff. Ultimately, the stressors could cause the nurse to resign from the institution.

The primary purpose of the study was to test the complete stress-response sequence model in a sample of pediatric oncology nurses by obtaining concurrent measures of the model's individual components. These components included nurses' stressors, reaction, mediators, and consequences. The study was a descriptive survey design from which objectives were achieved. The sample size was all full and part-time registered nurses who were employed in the Division of Nursing in a major cancer center (n=190). A total of 126 nurses responded to the study.

Nurses were asked to respond to six questionnaires. One instrument used was the Stressor Scale for Paediatric Oncology Nurses (SSPON), which was

developed to measure the internal and external environmental events and conditions that can change a pediatric oncology nurse's emotional or cognitive state, consequently producing physical or psychosocial reactions. The SSPON has six sub-scales, which were described by the researchers. The Perceived Stress Scale (PSS) measured the strength of reactions to situations that the respondent considered stressful. The PSS is a 14-item, 5-point Likert-type scale that was developed by Cohen, Kamarck, and Mermelstein (1983). Scores range from 0 to 56, with higher scores being indicative of stronger reactions to stressors. The PSS has moderate internal consistency, with reports ranging from 0.84 to 0.86, and some evidence of concurrent validity. In the present study, the Cronbach's alpha was 0.89. Other questionnaires included Measure of Job Satisfaction, Organized Commitment Questionnaire, Group Cohesion Scale, and Intent to Leave. A demographic sheet was also utilized.

Descriptive statistics were used to analyze each of the components of the model. Findings in the area of Stressors indicated a moderate intensity of role-related stress in the study's participants. Reactions findings from the PSS indicated moderate strength reactions to stressful situations. Consequences findings revealed that the highest item mean scores on the MJS were in the Personal Satisfaction subscale, and the lowest were in the Prospects subscale. The overall scale mean score of the OCQ showed a high level of organizational commitment, which was higher than that for eight groups of professional and technical employees.

The overall findings from the study indicated that pediatric oncology nurses at the study setting experience role-related stress. The stress seemed to peak in the 30-34 year-old nurses, and is lowest among the 40-44 year-old nurses. Although nursing is a stressful profession, the nurses reported positive role-related outcomes with high job satisfaction scores, high levels of organizational commitment and strong group cohesion. The researchers recommended further studies relating to what nurses find meaningful.

In a related study, Oermann and Moffitt-Wolf (1997) sought to describe the stresses and challenges experienced by graduate nurses in clinical practice during the time of their initial orientation period to the hospital setting. In addition, the researchers sought to examine the relationship of social support to these stresses, challenges, and threats. The researchers acknowledged that it is important to examine clinical experiences of new graduate nurses because excessive and unrelieved stress may influence job satisfaction, thus contributing to job turnover.

The researchers conducted a thorough literature review. Several themes were identified, including the effectiveness of preceptorship and internship programs to enhance recruitment and retention of new graduate nurses. The authors pointed out that the actual identification of stressors experienced by new graduates in their initial clinical practice is limited in the literature. Closely related to stressors experienced by new graduates was in a study by Nayak (1991), who examined the work experiences of new graduates and the relationship to social support. The majority of the respondents indicated that their family and friends

provided social support (84%), and only 22% reported that professional relationships provided them with needed social support.

Three research questions were addressed: The first was to determine the stresses, challenges, and threats of the initial clinical experience as described by graduate nurses; the second was to determine if there was a relationship between the stress experienced by graduate nurses during orientation and social support; the third was to determine the perceptions of graduate nurses of their initial clinical experience during orientation. A descriptive-exploratory design was used to examine the stresses, challenges, and threats experienced by graduate nurses during orientation to their first nursing position and the relationship of these to social support.

The sample was relatively small, with only 35 new graduates volunteering to participate in the study. The researchers did not state that the sample was randomly selected, only that the nurses volunteered to participate. In addition, only 42% (n=15) of the graduates were from a BSN program. Instruments used for the study included a demographic data sheet, social support instrument, and modified Pagana Clinical Stress Questionnaire. The social support instrument was developed and pretested by the researchers prior to implementation of the study. This social support instrument consisted of a series of questions in which subjects identified five people who provided social support and then rated the degree of support on a 5-point Likert-type scale.

The Clinical Stress Questionnaire, developed by Pagana (1989) consisted of open-ended questions and a Likert-type scale which identified stresses,

challenges, and threats of clinical practice. Pagana (1989) reported reliability in the original study, but it was not indicated by the researchers. However, the study conducted by the researchers reported the Chronbach alpha coefficients for the emotions scale from .80 to .89.

Results of the study indicated that the graduates experienced a moderate degree of stress. The mean stress score was 2.65 (SD=.85) based on the Likert-type scale, which ranged from 0 to 4, with 4 indicating a great deal of stress. Results also indicated that the graduates were challenged by their initial clinical experiences, with a mean score of 3.12 (SD=.64). Several stressors were identified by the respondents, including lack of experience, interactions with physicians, lack of organizational skills, and new situations and procedures. Medication administration, managing a large number of patients, inadequate orientation, and meeting a personal goal were all identified stressors. Furthermore, experiencing frequent interruptions, reliance on others and a perceived lack of support from other RNs on the unit were also noted as stressors by the graduates.

The results of the second research question which examined the relationship between the stress experienced by the graduates and their social support indicated that most respondents had an adequate support system. There was no significant relationship between social support and stress; however, there were significant positive correlations between social support and stimulation in clinical practice and development of confidence in practice.

The third research question focused on perceptions of new graduates about their clinical practice experiences during orientation. Factors identified by the respondents that inhibited their learning in orientation included time limitations, frequent distractions, staff criticism, questioning from staff, feelings of anxiety and overwhelmed, and lacking needed guidance from preceptors. However, the graduates indicated that consistent preceptors who provided positive reinforcement and guided their learning, self-motivation, a well-planned orientation, hands-on experience, role models, and the opportunity to practice procedures facilitated their learning experience. The overall findings of the study were clear in the importance of the clinical preceptor in the orientation period.

A qualitative study was conducted by Boychuk-Duchscher (2001) that investigated newly graduated nurses in the acute care setting. This study was performed because minimal qualitative studies exist that explore optimal work environment for the acute-care, hospital-based practicing nurse, and even less evidence to detail the factors that exhaust, alienate, and discourage those professionally competent and caring nurses that are needed to attract and retain.

The study was a phenomenological qualitative approach, and explored how five nurses perceived their first six months as professional nurses. Purposive sampling was used, and five women were selected to participate in the study. The participants had graduated from a four-year baccalaureate nursing program within two months after the study began, and all were employed within three acute-care hospitals in a mid-sized Canadian city. The researcher acknowledged that the sample size was small, but stated that the small size

provided an opportunity for in-depth interviewing, reinterviewing, and ongoing journal reflection. However, a small sample size in a qualitative study should not be an issue.

Data collection consisted of a non-standardized, semi-structured interview schedule and technique. The first interview took place within two months of the new graduates practice as a RN, and the second interview was six months later. The interviewer constructed the questions, and effort was made to ensure that participants directed the course of the interview once the questions had been asked. The researcher also acknowledged that sympathetic feelings were experienced by her, especially in terms of the plight of the acute-care bedside nurse. This was seen as a limitation of the study.

Data were analyzed by using a constant comparative approach to identify major themes and to categorize collective data, with significant involvement of the participants in member checking the interpretations of the data. Three major themes evolved from the process, and these were 1) Doing nursing; 2) The meaning of nursing; and 3) Being a nurse.

Theme one, "Doing Nursing," included many experiences that the new graduates encountered. Dependency on others, fear of physicians, self-absorption, leaving the nest, the unwelcome wagon, and focus on doing were identified. Theme two, "The Meaning of Nursing," also identified some intense feelings from the graduates. The participants were emotionally, spiritually, and physically exhausted, and were growing weary of the dichotomies between what was learned in school and what the realities of practice. They were also

searching for more stability in their professional role expectations, and were accepting their inadequacies and imperfections. Theme three, “Being a Nurse,” evolved approximately five months into their practice as a RN. A sense of self-determination was gained, and the researcher described such ideas as puppet off a string, critical thinking, and professional maturation.

The findings of the study were disturbing to the researcher. The author expressed concerns about what could have been done to ease the transition into practice, and support the nurses. Nursing administrators and continuing nursing educators were strongly urged to consider the findings of this study to assist with new nurse orientation and retention. Such factors as supportive partnerships, adequate orientation, and the work environment should be considered by the hospital to help ease the stress of new graduate nurses.

Duncan (1997) explored the importance of the clinical experience of student nurses. Duncan (1997) recognized that these clinical sites can potentially serve as a future employer and employee relationship. The purpose of the study was to identify the influence of past work and clinical experience on the first year of employment by senior BSN nursing students. Many students are profoundly influenced by the clinical setting in which they practice as students. In addition, many students who work in the same facilities as nurse technicians are potential RN employees when they graduate. The researcher sought to investigate four research questions: 1) Is there a difference in the job factors nurses seek in their first RN position if they have or have not had past experience with their new employer? 2) Does pre-graduation experience with employers result in higher

pre-entry and one-year levels of commitment to organizations? 3) Does past experience reduce the level of turnover at the end of one year? 4) What aspects of past experience with organizations are most important to understanding organizational commitment at the beginning and end of the first year of RN employment (Duncan, 1997, p. 225)?

The sample consisted of all graduating BSN students in a mid-western university on three separate campuses. These students were six-to-seven weeks from graduating, and only students who had accepted a post-graduation position as a RN were eligible to participate (n=76). The response rate was 83% (n=64). All study participants were sent a follow-up questionnaire at the end of one year that included the Affective Commitment Scale. The response rate was 69% (n=47).

Findings of the study revealed that past student experience did not influence entry-level organizational commitment or commitment after the first employment year. This could indicate that previous exposure to an employer does not predispose a BSN graduate to commit to an organization at a different level than new graduates without prior experience. Findings of this investigation also indicated that experience with an organization alone does not influence organizational commitment; however, past experience in the environment which was perceived as warm and supportive significantly contribute to both pre-entry and one-year organizational commitments. A finding of particular interest was the higher rate of turnover for students who had past experience with their new employer. This may suggest that new graduates with no past experience may do

more job searching prior to selecting a position. The results of this study further indicated that the transition from new graduate to new nurse possibly begins before graduation while the student is still learning in nursing school.

A descriptive study conducted in Australia by Heslop, McIntyre, and Ives (2001) did not specifically examine new graduate nurses' stressors. However, the researchers sought to identify undergraduate nurses' expectations and their self-reported preparedness for the graduate-year role. This is a significant and appropriate study because the graduate year in nursing school often sets expectations for clinical practice. The initial nursing experiences of new graduate nurses most often occur in clinical settings of a health care facility. The work environment of the hospital settings becomes a critical component for graduate nurses to make an employment decision, influencing the transition process by enriching it or by diminishing it.

The sample consisted of Bachelor of Nursing students in their senior year (n=105). A researcher-developed questionnaire was distributed, and addressed such themes as expectations, fears, support expected, and perceptions of the graduate year role and program. The instrument was divided into four parts: Part A sought demographic information; Part B asked open-ended questions of participants to provide views on role expectations, preparation to practice, and main concerns and anxieties. Parts C and D consisted of structured responses of binary, nominal, or ordinal nature regarding similar areas.

Data in Parts A, C, and D were analyzed and the results were presented in frequency tables. The open-ended questions in Part B were analyzed manually

through the use of content analysis and recording the frequency of responses. The majority of the graduates hoped to join a graduate nurse program, which would assist the student in transitioning to the practicing RN role. The purpose of the graduate nurse program was to consolidate clinical skills learned in nursing school, gain support while adjusting to the RN role, enhance theoretical knowledge, and gain support while adjusting to organizational processes and procedures. Factors that helped determine which program the participants would choose included locality, reputation, clinical preferences, and familiarity. Other important factors indicated by the participants were selecting a hospital that they perceived to be less impersonal, more professional, and receptive towards students; in addition, they sought a program that would fund postgraduate education.

The majority of the participants indicated that they expected to be supported by a preceptor during the graduate program. They also expected regular formal feedback from their preceptor on their job performance. The participants also expected the organizational climate to be democratic, alienating, and frustrating, but primarily stable. In addition, the majority of the participants expected the graduate program learning environment to be challenging, friendly and supportive. Concerns were expressed about meeting performance expectations of the workplace because of their perceived lack of clinical experience. This student-centered study could add insight about student expectations and the actual work experience. Hospital and nurse managers

could gain significant insight into these perceived concerns and the workplace environment.

Charnley (1999) investigated occupational stress in the newly qualified staff nurse. The study was also conducted to explore the effectiveness of Project 2000 training, and examined the perceived occupational stresses experienced by these trained staff nurses during their first six months as practitioners. Project 2000 dramatically altered the preparation of nurses, and research was needed to explore the effect of the program.

A qualitative approach was used, and data collection and analysis was consistent with grounded theory methodology. Grounded theory does not attempt to verify pre-existing theory; rather, it focuses on the discovery of theory. A semi-structured interview was used to collect the data. The sample consisted of 18 newly registered nurses who had all graduated from a Project 2000 diploma course in the previous six months. All were employed in the hospital setting.

Data were analyzed by transcribing the tape recorded interviews. As the interviews progressed, key concepts were noted and grouped into categories. Categories were linked and refined in order to identify theoretical labels. Four major categories were identified: 1) The reality of practice; 2) Learning the system; 3) Developing clinical judgment; 4) Developing professional relationships. These categories are closely related to the qualitative research conducted by Boychuk-Druchschler, as described previously.

Category one, "the reality of practice," found that almost all participants experienced feelings of stress in their new roles and status. They also expressed

feelings of anxiety relating to the sheer volume of work. Feelings of guilt and resentment were also described, as well as concerns about lack of skills. In addition, the reality of practice was not congruent with the high standards taught in college. Staff shortages also contributed to the stress, because learning in practice is dependent on the availability and time of other staff.

Category two, “learning the system,” also identified much anxiety by the participants. Learning the environment was one concern expressed. However, it was noted that nurses who returned to units they had worked on as students did not experience as much anxiety with these issues. Time management and prioritizing were also noted to be areas of concern.

Category three, “developing clinical judgment,” noted that many of the participants did not possess the confidence to deal with the rigors of practice. The knowledge base was present, but the experience was not. Gaining confidence and experience is not learned in textbooks; it is learned by “doing.”

“Developing professional relationships” was category four, and again identified anxiety as a problem. Many expressed concerns about supervising health care assistants, and being accountable for their actions. Lack of role definitions were clearly a problem, as well as poor communication and lack of support among staff.

Project 2000 acknowledged the importance of support and guidance in the gaining of confidence in practice of the new graduate nurse. The use of preceptors was meant to enhance the transition and assist with coping and stress levels. However, the researchers noted that there is little evidence to show

how widely it is being introduced. Work overload, deficits in practical and management skill, evidence of theoretical gaps between educational priorities and the reality of practice, and lack of qualified support were the main factors that attributed to the stress. The researcher recommended that joint efforts by educators and employers be implemented to ease the transition from student to staff nurse. In addition, education curricula should reflect the clinical needs of the nurse in practice.

Job Satisfaction

The literature is more comprehensive with information relating to job satisfaction and the new graduate baccalaureate registered nurse. A study conducted by Winter-Collins and McDaniel (2000) explored the relationship between the sense of belonging and job satisfaction in the new graduate RN. Background information for the study indicated that there are many factors which influence the satisfaction of new graduates. Role conflict was identified by Kramer (1974) as a major problem for new graduates in their first job. In addition, job stress was identified by Hinshaw, Smeltzer, and Atwood (1987) as the strongest predictor of job satisfaction.

The theoretical framework for the study was based on Kramer's Model on Reality Shock (1974). This was an excellent theoretical foundation for this study, and stated that Reality Shock has four phases that are experienced by the new graduate. These phases are honeymoon, shock, recovery, and resolution. The researchers focused on the first two phases by limiting the study to the first 18 months of employment after taking the licensure examination.

A mail survey was used to assess the relationship between sense of belonging and job satisfaction in the new graduate RN. The researchers randomly selected 250 new graduates from an Indiana Health Professions Bureau mailing list of new graduates who took the state board exam between January 1996 and January 1997. The survey asked questions relating to demographics, work place environment, interpersonal relationships, and job satisfaction. The instrument used to measure job satisfaction was the Mueller-McCloskey Satisfaction Scale, which is a 31-question Likert-type tool. The instrument identifies eight types of job satisfaction, and has an internal consistency coefficient of 0.89 and 0.90. Sense of belonging was measured by a modification of the Hagerty-Patusky Sense of Belonging Instrument, which is also a Likert-type scale. This scale has a reported content validity index of 0.83. Demographic variables were examined by the use of descriptive statistics, and Pearson correlation was used to examine the degree and direction of the relationship between sense of belonging and job satisfaction.

The response rate was relatively low, with 107 surveys returned, or 43%, and only 95 of those surveys met the criteria of a new graduate as defined in the study. The majority of the respondents (69%) worked in acute-care hospital settings. In addition, only 38% (n=36) of the sample were baccalaureate graduates. Orientation in the work setting ranged from 0 to 36 weeks.

Results of Job Satisfaction indicated that the total satisfaction ranged from 1.9 to 4.5 on a 5-point Likert scale, with a mean of 3.5. Higher scores are indicative of higher levels of job satisfaction. The Hagerty-Patusky Sense of

Belonging instrument was described by the researchers as relatively new, and modifications were made for purposes of the study. Because of this, a reliability analysis was conducted, and the tool scored a Cronbach alpha coefficient of 0.86 in the reliability analysis. Sense of Belonging scores ranged from 1.9 to 3.5, with a mean of 2.9. Correlations were examined between sense of belonging, total satisfaction, and the satisfaction sub-scales. Significant correlation with sense of belonging existed with interaction opportunities ($p=0.000$, $r=0.38$), praise ($p=0.000$, $r=0.35$), control ($p=0.001$, $r=0.35$), coworkers ($p=0.001$, $r=0.33$), and schedule ($p=0.006$, $r=0.28$). The relationships between sense of belonging with extrinsic rewards ($r=0.20$) and professional opportunities ($r=0.21$). The strongest relationship was between sense of belonging and new graduate total satisfaction ($p=0.000$, $r=0.40$).

Findings of the study supported the need for a nurturing environment for the new graduate registered nurse. The researchers recommended that future studies investigate satisfaction with orientation programs in relation to sense of belonging and total satisfaction. The researchers also identified a limitation in the study, as the length of time position did not give a true indication of retention. The information gained from this study should be a clear indication to managers that every effort should be made to increase new graduates' sense of belonging and job satisfaction.

A study conducted by Fletcher (2001) examined RNs' job satisfactions and dissatisfactions. Increasing inpatient acuity, technology, and the use of ambulatory services has validated the demand for RNs to be retained. These

factors, along with the growing nursing shortage warrant the need for research relating to job satisfaction.

The purpose of the study was to examine whether stress in RNs was associated with their illnesses or injuries. The population consisted of 5,192 RNs who were employed by 10 hospitals in southern Michigan. There were 1,780 usable responses (34.5%). Numerous questionnaires were used in the study. The Specific Satisfactions Subscale from Hackman and Oldham's Job Diagnostic Survey is a 14-item tool with five subscales examining job satisfactions. These subscales are pay, job security, social, supervisory, and growth satisfaction. The mean job satisfaction rating was 5.040 (SD=.99) on a scale of 1 (extremely dissatisfied) to 7 (extremely satisfied). This indicated that the RNs were slightly satisfied with their jobs.

Other scales used were The Immediate Supervisor that asks about supervisor qualities, including reliability, competency, and helpfulness. Also used was The Health Professions Stress Inventory, which compares levels and sources of stress in a variety of health professions. Scores on this instrument indicated that RN jobs were sometimes to some extent stressful. The participants were also asked the question, "As a life goal, how likely is it you will stay in the nursing profession?" Responses to this question revealed that the participants were likely to remain in nursing. Space was provided at the end of the booklet allowing RNs to write and comments. According to the author, 509 (28.6%) of the nurses took time to write about their hospital work experiences. These comments were a clear indication of job dissatisfaction in the hospital.

Career and job satisfaction narrative results were highlighted by the researchers. The majority of the study, in fact focused on comments made by the nurses participating in the study. Issues such as profits for the hospital were stress causing, as many of the nurses had survived restructuring and downsizing. Many respondents perceived that profits over patient care were administration goals. However, several nurses commented that they were dissatisfied with their co-workers' attitudes and job performance. Administration was not the only target for the nurses' comments. Most nurses in the study indicated that they enjoyed caring for patients and making a difference in their lives. They love nursing, but were distressed when patient care suffered because of organizational constraints and changes.

Many nurses responded to extrinsic work factors, and felt that nurses were underpaid and underappreciated. Many nurse managers expressed frustration at their increased workloads and need to be away from unit-based supervision. Staff expressed concerns about lack of the manager's presence on their unit. Staff nurses also were distressed about short staffing issues, and felt that management was not concerned about this.

Nurses responding to the study indicated that although they may choose to stay in the profession, their reasons for doing so were not reassuring. Many stated they intended to leave because of low pay and stress. Many are pursuing other careers, and not encouraging others to enter the profession. The researchers acknowledged that although it would be easy to dismiss the negative comments from the nurses in the study, management should take note of the

comments made by the nurses. Limitations identified by the researchers were clear: one can not assume that the negative comments are representative of all nurses. In addition, the 34.5% response rate was somewhat low, and may not include necessary data from other nurses.

Brighid (1998) conducted a follow-up study with new graduate nurses. The purpose of the study was to describe, explain and interpret how new graduate nurses perceived their adaptation to the “real world” of hospital nursing. In addition, the study sought to determine the major influences on their moral values and ethical roles in the two years following graduation.

The method was a grounded theory qualitative approach. The earlier study took place when participants were senior nursing students. The follow-up study took place after the participants had been practicing for one year. The research questions that guided the study were how do new graduate nurses describe their adaptation to the “real world” of nursing, and what do they describe as factors influencing their moral values and ethical roles in hospital nursing?

The sample consisted of 22 of the original 23 participants who were new graduate baccalaureate nurses. Data were collected through the use of open-ended, in-depth, audiotaped interviews, and were analyzed by classifying patterns and themes. A six-stage psychosocial process explaining how the new graduates perceive their adaptation to the “real world” of hospital nursing was identified. These stages are vulnerability, getting through the day, coping with moral distress, alienation from self, coping with lost ideals, and integration of new

professional self-concept. The principal theme identified that linked all of the stages was moral integrity, and was selected as the core variable in the study.

The study emphasized the importance of social forces in the maintenance of professional values and of a valued professional identity. Disparity from what the new nurses expect from themselves and what they actually experience in practice can predispose them to moral distress. Nursing curricula must acknowledge that students need to learn how to deal with the unexpected and learn from it. Hospital and nurse managers need to be aware that lack of support leads to psychosocial stress and decreased job satisfaction. The researchers strongly recommended that more studies be done investigating moral distress in practice.

Another study related to nurses' job satisfaction was conducted by Blegen (1993). The purpose of the study was to describe the extent of the relationships between nurses' job satisfaction and the variables most frequently associated with it in previous studies. The literature was reviewed using multiple databases in search of published and unpublished studies. The studies had to report analysis of quantitative data from samples of nurses. Forty-eight studies met the criteria for inclusion. Individual sample sizes ranged from 30 to 1597, for a total of 15,048 participants. Hospitals were the most common work facility, with 79% of the total population employed there.

Results of the study indicated that the strongest relationships with job satisfaction were stress (-.609) and commitment (.526). Other variables identified had estimated correlations of moderate size, and included supervisor

communication, autonomy, recognition, routinization, and communication with peers. Variables with small to moderate relationship included fairness and locus of control. Of interest was that results indicated that age, years of experience, education and professionalism had small correlations with job satisfaction.

The researcher reported that findings of this meta-analysis study should be of use to those attempting to build better theories of job satisfaction. Nurse managers and administrators should also take note of these findings, as they are critical elements for job satisfaction and retention.

Olson et al. (2001) conducted a study examining the nursing student residency program, a model for a seamless transition from nursing student to RN. The researchers noted that one large issue for hospitals is the length of time it takes for a new nursing graduate to become oriented to the professional work environment. Three major hospitals in southeastern South Dakota met and started a pilot project similar to the Veterans Affairs Learning Opportunities (VALOR) program. The project was a residency program that provided 900 hours of preceptorship experiences for senior baccalaureate students by experienced RNs. The anticipation was that orientation and RN turnover costs for the institution would be reduced by early socialization, increased competence, and perceptions of familiarity and confidence among these nurses in their first professional RN position.

Four research objectives were used to evaluate the outcomes of the project. Objective one was to describe the changes in the students' vision of what it means to be a nurse at the beginning of the project, at graduation, and after

one year of experience. The second objective was to evaluate changes in the students' professional performance dimensions, medication administration and intravenous knowledge, and critical thinking skills from the beginning to the end of the program. Objective three was to document the students', preceptors', and head nurse supervisors' perceptions of the benefits of the program and recommendations for improvement. Objective four was to calculate the cost difference between the program and routine new graduate RN orientation.

Representatives were from three schools of nursing and three large Midwestern hospitals. The plan was developed by a collaborative effort from the representatives. The student sample was selected from the associates who were enrolled in the two baccalaureate programs and who were within one year of graduation. Demographic data were collected from the students who applied.

Methodology consisted of each applicant participating in two interviews with hospital human resource representatives. Nine female students and one male student were selected for year one, and four female students for year two. Four instruments were used to collect data on professional performance dimensions, knowledge, and critical thinking.

The researchers found that the students' vision of nursing in terms of roles, values, and meaning of work changed from textbook responses to showing increased insight into the level of autonomy expected in a nursing role, as well as the accountability that comes with this role. Students gained comfort and knowledge and skills, and felt ready to assume their roles as a staff RN. The

head nurse and supervisors noted that the participants moved ahead more quickly and were more competent in performing new functions.

The researchers noted that there were only 14 participants in the study, and it was more expensive on a per-graduate basis. However, the program participants needed less orientation time than those who were not preceptored. All three hospitals decreased their orientation time. The researchers also noted that the findings of this study could assist with retention and prevent future nursing shortages.

Job Retention/Intention to Leave

Literature relating to job retention and intention to leave is often associated with job satisfaction. Shader, Broome, Broome, West, and Nash (2001) conducted a study that used a cross-sectional survey design. The purpose of the study was to answer four research questions, including 1) What is the relationship between job stress, group cohesion, stability of schedule, and anticipated turnover? 2) Which factors best predict anticipated turnover? 3) What factors predict anticipated turnover for nurses of different age groups? And 4) Is there a relationship between anticipated turnover and actual turnover (Shader et al., 2001, p.212)? Self-report questionnaires were used to measure the nurse perception of job stress, work satisfaction, group cohesion, and anticipated turnover. Demographic data were collected from existing hospital databases.

The sample consisted of five nurse managers and 241 staff nurses from 12 units in a 908-bed university hospital in the Southeast. Of the 390

questionnaires that were distributed, 241 were usable, or a return rate of 63% for staff RNs and 42% for the nurse managers.

The Instrument used to measure work satisfaction was the Index of Work Satisfaction (IWS). The IWS consists of two parts, A and B. Part A determines the perceived importance of factors essential to satisfaction, and Part B measures the current level of satisfaction.

Findings of the first research question revealed that nurses reported moderate levels of job stress. The group cohesion reflected an above average perception of cohesion of the clinical units. The work satisfaction mean was at the midpoint of the scale, and the mean score on the anticipated turnover rate was slightly below midpoint.

Pearson's correlation analysis was done on all major study variables. Results indicated that the more job stress, the lower group cohesion ($r=0.41$, $p<0.001$), and the higher the anticipated turnover ($r=0.37$, $p<0.001$). Likewise, the higher the work satisfaction, the higher group cohesion ($r=0.42$, $p<0.001$) and the lower anticipated turnover ($r=-0.47$, $p<0.001$). The more stable the schedule, the less work related stress ($r=-0.205$, $p<0.001$), the higher group cohesion ($r=0.43$, $p<0.001$) and the higher the work satisfaction ($r=0.44$, $p<0.001$).

In order to analyze research question two, a step-wise regression model was conducted. Results indicated that work satisfaction, weekend overtime, job stress, and group cohesion were all predictors of the anticipated turnover rate. Research question three, addressing factors that predict anticipated turnover for nurses of different age groups, had interesting results. For all age groups, work

satisfaction was predictive of anticipated turnover. However, for the 20 to 30-year old nurse, job stress was included, and for the 41 to 50 year-old nurse group cohesion was a factor. The nurse 51 or older had no turnover predictions.

The researchers recommended that nurse managers examine the variables of this study to assist with nurse retention. Further recommendations included that organizational strategies address and reduce the staff nurse's frustration.

Gardner (1992) specifically studied conflict and retention of new graduate nurses. The purpose of the study was to examine the levels and types of conflict perceived by new graduate nurses in their first year of work and to investigate the relationship of conflict with job satisfaction, performance, and turnover in the new nurse. The sample targeted was 350 of the registered nurses who joined a large Midwestern hospital over a 15-month period. Ninety-one percent of the RNs (n=320) agreed to participate in the study. Of the 350 nurses, 166 were new graduates.

Two questionnaires were administered, one at six months and the other at 12 months after the beginning date of employment. Job satisfaction, commitment, professionalism, and performance were all addressed in the questionnaires. In addition, demographic data were also collected. The variable conflict was measured by the Perceived Conflict Scale, which was developed for this study. A test-retest reliability correlation coefficient was .77 when identical forms were administered two weeks apart. Construct validity was demonstrated when the scale inversely correlated with the measure of job satisfaction.

Job satisfaction was measured by the McCloskey-Mueller Satisfaction Scale. Performance was measured by the Six-Dimension Scale of Nursing Performance, which can be applied to both recent graduates and experienced nurses. This scale was only administered at 12 months. Turnover data were collected from the use of administrative records as actual separation from the organization.

Results of the study indicated that perceived conflict in the new graduate hospital nurses over the first year of employment was moderate and stable from six to 12 months of employment. Highest mean scores and scores that increased over time were from intrapersonal conflict. The researchers noted that the buildup of role conflict in the job setting may just begin to show up at approximately 12 months of employment. Nurse managers should note this, especially for the new graduate, to assist with retention. Overall, the research indicated that job conflict has an inverse correlation to job satisfaction. It is recommended by the researcher that more studies be conducted addressing job conflict.

In a related study, Yoder (1995) investigated the range of career development relations (CDRs) experienced by staff nurses in relation to the outcomes of professionalism, job satisfaction, and intent to stay. This study did not, however, focus on new graduate nurses. It is significant because the researcher discussed the importance of mentoring, which has been strongly associated with retention of new graduate nurses.

The sample consisted of 390 Army staff nurses who practiced in seven clinical specialties. The majority of the nurses were BSN graduates (82%). Fifty-one percent of the nurses (n=200) had been a nurse for one to five years. Four instruments and a demographic questionnaire were used in the study. These questionnaires measured five CDRs, including precepting, peer-strategizing, coaching, sponsoring, mentoring, and the outcome variables. The Alleman Mentoring Scales Questionnaire (AMSQ) was used to obtain information about the most significant CDR experienced by respondents thus far. For purposes of the study, CDRs were viewed as occurring on a continuum in which precepting was on the low end and mentoring of the highest end.

Research results revealed that 61% of the sample experienced a CDR, and the predominant CDR was coaching. The study also indicated that no CDR affected professionalism, but job satisfaction and intent to stay possibly warrants further investigating relating to CDRs. It was acknowledged by the researcher that the use of military nurses verses civilian nurse may limit the generalization of findings. It was recommended that the study be conducted including civilian nurses.

Fisher et al. (1994) examined selected predictors of registered nurses' intent to stay on the job. The purpose of the study was to identify variables that could be used to develop managerial interventions to increase the RN's intent to stay on the job. Variables explored in the study to identify the nurses' influence on intent to stay included professional autonomy, managerial environment (ME), willingness to risk, and nurse propensity to exit/voice (E/V). The hypothesis was

professional autonomy, managerial environment, willingness to risk and nurse propensity to exit/voice predicts registered nurses' intent to stay.

The population was inclusive of all RN staff nurses employed at least half-time in eight adult acute-care hospitals located in a Midwestern metropolitan area. The full sample size was large (n=1613); however, 524 staff nurses returned usable study packets. Data were collected over a five-month period, with the average RN being 36-years-old with a BSN educational level. Unlike previous studies concerning new graduate nurses, the majority of this sample had been practicing for more than 11 years. This is significant because most of these nurses had been employed in at least two previous institutions.

Several instruments were used to measure the constructs of interest and were derived from a ME scale (Tomey, Bakas, and Deets, 1990), the E/V scale (Graham, J., 1982), a researcher-designed risk scale which tied to the E/V scale, the autonomy scale (Velianoff, 1986), and a semantic differential scale on risk (Graham, J., 1982). The researchers indicated that two logistic regression analyses were computed to test the predictive relationships of the independent variables. In the first logistic regression analysis, subjects with neutral ITS scores were grouped with subjects who had no intent to stay. Both ME and E/V were predictive of ITS. The second analysis consisted of subjects with neutral ITS scores who were grouped with subjects who intended to stay. Only ME was predictive in this case.

The researchers pointed out that although many of the nurses in the study had held at least two previous jobs, many nurses also moved within the facility.

This retention of staff within the institution may be less costly than having to replace nurses who leave. It was clear from the research that nurses were more likely to stay on the job if they held the perception that they had some input in decision making to management.

A study conducted by Mills and Blaesing (2000) explored the relationships that work values have on the satisfaction that nurses experience with a career in nursing. Although this study does not specifically target new graduate RNs, it is significant because the impact that job satisfaction has on all nurses invariably affects the new graduates. The authors acknowledged that the satisfaction of RNs and the concern with how they view their work and professional career are recurrent issues for managers, nurses, and scholars. Whether there is a nursing shortage or surplus, the reports of low levels of job satisfaction exist among nurses.

Data from the study was obtained from a questionnaire developed, distributed and collected by the Missouri Hospital Association (MHA) in 1989. There was a severe national nursing shortage at the time data were collected; therefore, it was an appropriate time to implement the study. Ninety-two hospitals agreed to participate, and approximately 10,000 surveys were mailed. The individual hospitals further distributed the questionnaires to the nurses. Four thousand questionnaires were completed, with 3298 usable for purposes of the study. The MHA provided the researchers with the questionnaires for secondary data analysis.

Nurses were asked to complete demographic information and a checklist of positive aspects of nursing. The purpose of the questionnaire was not to produce a satisfaction measurement scale, but to have nurses identify positive aspects of nursing to assist in improving public image of nursing during a critical shortage period. Results of the study revealed that the majority of the nurses were employed at their hospital from one to 26 years; however, the study does not indicate years of experience as a RN. According to the researchers, data revealed that 54% of the respondents would choose nursing again, and 55.6% would encourage others to select nursing as a career option.

The majority of the nurses indicated that patient care rewards were the reason why they entered nursing, and why they would choose it again. Of special interest was the finding that nurses employed full-time were twice as likely to choose nursing again. Conversely, nurses who worked part-time did not show a consistent pattern in their satisfaction responses. Hospital nurses employed in major urban areas were more satisfied with nursing as a career than those employed in rural areas. Salary was a work value that was related to a higher likelihood for nurses to be satisfied with their career in nursing.

The result of the previous nursing shortage was downsizing and restructuring of hospitals. The findings from this study on data analyzed from the last nursing shortage indicated that any organizational restructuring or work redesign activities could be perceived as 1) demeaning a nurse's sense of professional status; 2) altering the rewards received in the nursing-patient relationship; and 3) threatening pride in the profession would result in nurses

having dissatisfaction with their career (Mills and Blaesing, 2000, p.314). The researchers indicated that a learned lesson from the last nursing shortage is that in effort to realign the nursing organization to meet external threats cannot alienate the staff nurses from their core work values. The present nursing shortage will surely be affected by the tarnished image of the profession. Management and administrators should listen and learn from the nurses responding to the study.

McKee (1994) conducted a study to determine if orientation affects retention of nurses. New employee orientation is a major expense for hospitals; therefore, the researcher hypothesized that job satisfaction might be related to the types of orientation offered.

The sample consisted of 11 hospitals in a large, Midwestern city. Ten new RNs were randomly selected per quarter to participate. Data were collected on each orientee, and names were coded to maintain confidentiality. Types of orientation were coded A through G, and data were collected for one year from the hiring date. Orientation was conducted in a one- or two-week time frame by the staff education department, and then the orientee worked with a preceptor on the assigned clinical unit.

Results of the study found that there was no statistical significance in relation to the orientation type received. Thus, the study did not demonstrate a relationship between turnover and the variable orientation. It was suggested that turnover is more complex than one variable.

Implications for nursing staff development were made by the researcher. It was noted that many factors affect an individual's intent to leave the job. Therefore, initial orientation should be a positive, growth-filled experience. In addition, the process should be under continuous evaluation, and exit interview data should be collected. Changes in the orientation program should not be made unless it is indicated by findings.

A study conducted by Ames et al. (1992) sought to assess work retention issues within the hospital setting. Although not specifically geared toward new graduates, this study is significant because it impacts new graduates as they enter their professional nursing roles. This study was conducted because of the nursing shortages and high turnover rates among the nation's hospitals.

A tool was designed for the study that sought to determine what work-related factors were important and satisfying to staff, leading to information about why staff remains employed in the hospital. The retention survey consisted of 33 items grouped into five categories. Each item required response on a Likert-type scale. The process of tool design, administration, and survey return took less than six months. A pilot study was initially conducted on two clinical units to assess the tool, and necessary adjustment was made as a result of this.

The sample consisted of all nursing personnel involved in patient care (N=1150), and an 85% response rate was obtained. Findings indicated that nursing personnel rated all subscales higher in importance than in satisfaction. Team playing was found to be moderately to very satisfying. As a result of the findings, work groups were formed to intervene with dissatisfiers found from the

surveys. These findings were communicated to the entire hospital to assist with staff retention.

T. Graham (2002) reported on a research study that was done in collaboration with Nurse Week nursing journal and the American Organization of Nurse Executives (AONE). The landmark national research study of registered nurses sought to learn their career intentions and perceptions of their work environment. Although this study did not target new graduate nurses, it is significant because information gained from the findings could dramatically impact the retention of new graduates.

The sample size was 4,100 RNs across the United States. The findings of the study revealed that America's nursing shortage has worsened during the past year and is negatively impacting patient care. However, despite the shortage, most nurses were satisfied with nursing as a career choice. The findings also indicated that most nurses believe that their employers share their commitment to quality patient care, which was considered renewed hope that together solutions can be found and implemented to improving patient care.

Suggestions to increase retention of nurses included higher salary or benefits, more respect from management, and better staffing. These findings are consistent with the literature regarding new graduate nurses. Fifty-four percent of the participants stated that the main reason for the nursing shortage was poor salary and benefits, and 47% stated that there are now more career choices for women. Regarding plans to leave their present position, the majority (56%) stated that they had no plans to leave within the next three years.

The researchers stated that reducing stress in the work environment, which is a leading cause of nurses leaving the profession prior to retirement, will be especially challenging because this stress is a result as well as a cause of the shortage. Nurses overall believe that nursing is a good profession, and hospital and nurse managers should listen to the respondents of this study, as they represent a large sample of the practicing RNs in our country.

Summary

A comprehensive review of the literature revealed that the stress of new graduate baccalaureate nurses working in acute care hospital settings is significant. In addition, job turnover continues to be a tremendous factor for the institutions and the staff nurses. The literature clearly indicated that new graduate nurses perceive their jobs as stressful. Such variables as lack of orientation, lack of peer and management support, and an overall poor working environment were identified in almost all of the studies. The critical shortage of RNs has further impacted the stress of new graduate nurses, as there is a perceived lack of guidance and support from experienced nurses at the bedside.

Although the literature has numerous studies regarding stress of the new graduate nurse and job satisfaction, few studies have determined if a relationship exists between the stress associated with selected job related factors and the intention to leave the job. More information is needed in this area, and could assist hospital and nurse managers to retain much needed acute care nurses.

CHAPTER 3

METHODOLOGY

The purpose of the study was to explore the lived experience of new graduate baccalaureate-prepared Registered Nurses (RNs) who work in acute care hospital settings. This phenomenological study focused on eight new graduate RNs who worked in three different hospitals in a mid-sized metropolitan south Louisiana city. These nurses participated in interviews with researcher-developed guiding questions to generate thought and inquiry. The interviews were audiotaped, transcribed verbatim, and reviewed numerous times for data analysis and emerging themes.

This chapter presents the research design and detailed methodology for the study. Information regarding qualitative research design will be introduced and explained, including a detailed description of the phenomenological genre. The participants will be described, and guiding questions will be presented. In addition, the procedure for data collection and analysis will be described.

Qualitative Research

The study was a qualitative research design. The ultimate purpose of qualitative research is learning, and it is unique because the study is conducted with the researcher as the instrument. In addition, qualitative research seeks to learn about some facet of the social world (Rossman & Rallis, 2003). According to Eisner (1991), qualitative inquiry signifies a new way of thinking about the nature of knowledge, and how it can be created. Qualitative inquiry seeks to make it possible to better understand and appreciate the phenomena being

studied. Qualitative researchers have the belief that the basis of knowing is meaning, discovery, words, and uniqueness (Patton, 1990, as cited in Norwood, 2000).

Essentially, the purpose of qualitative research is to discover, explore, and describe phenomena, and this is carried out from the participant's point of view. It assumes that reality is fluid and different for each individual, and meaning occurs only within a given situation or context (Parse, 1996). Because qualitative research is from the perspective of the participant being studied, it is especially useful in areas where limited research has been conducted when theory testing is not possible because the variables relating to the concepts of interest have not yet been identified (Chenitz & Swanson, 1986; Patton, 1990).

Patton (1990) described several concepts that are unique to qualitative inquiry. The first concept is that of Naturalistic Inquiry, which implies that the researcher does not attempt to manipulate the research setting. The researcher seeks to understand "naturally occurring phenomena in their naturally occurring states" (Patton, 1990, p.41). Because qualitative methods tend to be oriented toward exploration, discovery, and inductive logic, the evaluation approach is the second concept described by Patton (1990), which is usually inductive in nature. Inductive analysis implies that analysis starts with specific observations, and builds toward general patterns. From these open-ended observations, patterns, categories, themes emerge as the researcher begins to understand the phenomena under study (Patton, 1990). The third concept described by Patton (1990) is the importance of fieldwork in qualitative inquiry, where the researcher

has personal and direct contact with those being studied in their own environment. The fourth concept is the importance of a holistic perspective, where the researcher seeks to understand a phenomenon as a whole. According to Patton (1990), “this holistic approach assumes that the whole is understood as a complex system that is greater than the sum of its parts” (p.49). Thus, understanding the social environment is critical to understanding the complete complex of what is being studied. Other concepts that Patton described as essential in qualitative inquiry include empathic neutrality, a dynamic, developmental perspective, and empathy and insight (Patton, 1990). Design flexibility is also important because the naturalistic approach to the inquiry is difficult, if not impossible to implement. Since variables are not being manipulated, the researcher understands that the qualitative design presents itself as the fieldwork unfolds (Patton, 1990).

Reliability and Validity

Determining reliability and validity in qualitative research can be complicated by numerous variables. Measurement in qualitative research relates to the judgments made by a researcher about the data collected in relation to its accurate representation of the phenomenon of interest, its comparability with known information, and its verifiability across subjects and situations (Brink, 1991). Because qualitative research focuses on the uniqueness of human situations and the importance of experience, it is essential to recognize that the traditional validation typically associated with quantitative forms of empirical

evidence is difficult. Rather, reliability and validity in qualitative research is considered in terms of dependability and credibility (Norwood, 2000).

Dependability in qualitative research is accomplished when the interpretation of the findings has “stabilized over time and across conditions” (Norwood, 2000, p.291). According to Sandelowski, (1986), auditability is an important criterion that ensures the dependability of the findings. Auditability is accomplished when another researcher is able to follow the qualitative researcher’s decision trail and ultimately arrive at the same conclusions, considering the researcher’s data, perspective, and situation.

Credibility in a qualitative study is comparable to validity. The qualitative researcher can be assured that the study is credible when confidence can be placed in the data and their interpretation. Credibility is dependent on whether or not the study was carried out and the findings are believable, and whether or not steps were taken to confirm the accuracy of the findings of the findings (Norwood, 2000). Strategies that can augment credibility of qualitative research include purposive sampling and ensuring that sufficient time was spent by the researcher in the field. The researcher can then be confident that data collection was continued until saturation occurs (Norwood, 2000). Other strategies that the qualitative researcher can use to accomplish credibility are carrying out member checks, where the findings are verified by the study’s participants. Interrater reliability can also be done, where another researcher reviews and confirms data interpretation. Detailed quotes from study participants can also be used to strengthen credibility, as this substantiates the researcher’s interpretation of the

qualitative data set (Norwood, 2000). The researcher can also set the data and interpretation aside for a period of time, thus ensuring intrarater reliability (Norwood, 2000).

The researcher can also use the process of triangulation in a qualitative study to assist with credibility. Triangulation is the approach of using several referents in a study in order to converge on the truth. Essentially, the researcher seeks to use several methods or viewpoints to obtain the most accurate and comprehensive picture of the phenomenon being studied (Kimchi, Polivka, & Stevenson, 1991; Patton, 1990). Denzin (1978), described several approaches to triangulation: (1) data triangulation involves the use of several different data sources in the study; (2) investigator triangulation is the use of numerous researchers or evaluators; (3) theory triangulation, where a variety of perspectives are used to interpret a single data set; and (4) methodological triangulation, which involves multiple methods to study a single problem or program.

According to Patton (1990), triangulation “is ideal” (p. 187). Studies that rely primarily on a specific method, such as interviews or observations, may be more susceptible to errors that are linked to that particular approach. Triangulation can be accomplished within qualitative inquiry by combining a variety of qualitative methods, mixing purposeful samples, and including numerous perspectives (Patton, 1990). Because my research involved in-depth interviews, I used investigator triangulation, where three other individuals evaluated my transcripts. Two of the evaluators were RNs with extensive experience in

nursing. One was an educator in a baccalaureate nursing program, and the other was a Nurse Practitioner who also had extensive experience as a nurse educator. In addition, my major professor reviewed all transcripts and provided insight and evaluation about the interview. The transcript evaluation validated my findings, and served to strengthen internal validity of the study.

Qualitative research has a variety of genres from which a study can be developed and implemented. All of the methods seek to describe the complexity of human experience in its context and learning from participants (Lipson, 1991). However, some common lens from which the researcher can consider the phenomenon are ethnography, grounded theory, and phenomenology.

Ethnographic studies focus on culture, and were derived from cultural anthropology and qualitative sociology (Rossman and Rallis, 2003). Cultural groups or communities are studied by ethnographers, and the work involves long-term immersion, called participant observation, into an intact cultural group (Rossman and Rallis, 2003). However, the time commitments necessary in an ethnographic study is often prohibitive; therefore, many researchers conduct mini-ethnographies, where the questions and techniques of ethnography are used. Observations, formal and informal interviews, and interpretation of artifacts are used by the ethnographer, and the researcher's personal experience of the events are used as data collection strategies (Rossman and Rallis, 2003).

Grounded theory research initially focuses on "unraveling the elements of experience" (Moustakas, 1994, p.4). Theory is ultimately developed where the researcher is able to understand the nature and meaning of an experience of a

particular group of individuals. The researcher does not lay out steps in advance; instead, each research project consists of its own detailed sequences that are dependent upon the available data, interpretations, and researcher experience (Strauss, 1987).

Grounded theory researchers continuously question any gaps found in the data. Questioning these omissions, inconsistencies, and incomplete understandings assist the researcher in “obtaining any information on what influences and directs the situations and people being studied” (Moustakas, 1994, p. 5). Moustakas (1994) further explained other beliefs that are unique to grounded theory research, such as the “open processes in conducting of researcher rather than fixed methods and procedures,” and recognizing the “importance of content and social structure” (p.5). In addition, grounded theory is inductive, where theory should grow out of the data and be grounded in that data (Moustakas, 1994).

Rationale for Phenomenological Lens

Specifically, my study was a phenomenological approach, a genre of qualitative research that seeks to explore the lived experience of a small number of people (Rossman & Rallis, 2003). Phenomenology aims to determine what an experience means to an individual who has had the experience, and then provide a comprehensive description of it (Moustakas, 1994). In-depth, intensive interviews are conducted between the researcher and participant, where the researcher seeks to gain an understanding of the deep meaning of the experience (Rossman & Rallis, 2003).

The intentions of Phenomenologic Inquiry are “description, interpretation, and critical self-reflection into the world as world” (Van Manen, 1990, p. 5). Intentionality, or the internal experience of being conscious of something, and caring are central concepts in phenomenology, and throughout the process the researcher engages in critical self-reflection about the topic and the process. (Moustakas, 1994; Rossman & Rallis, 2003). Detailed field notes of the interviews and experience are maintained by the researcher to assist with data analysis, and provide an improved understanding of the lived experience of the subject being studied.

Throughout this process, the researcher attempts to bracket or connect the assumptions that are brought to the study in order to identify the phenomenon in its “pure form, uncontaminated by extraneous intrusions” (Patton, 2002, p. 485). The final product articulates the deep composition of the lived experience of the participants’ phenomena (Rossman & Rallis, 2003). The philosophical foundation of phenomenological qualitative research served as an appropriate approach to the study. It was selected because it provided the researcher with an appropriate method to study the lived experience of new graduate baccalaureate nurses who work in acute-care hospital settings.

Pilot Study

In order to be assured that my guiding questions were comprehensive, I conducted a pilot study with four participants. Prior to initiating the pilot study, I met with members of my dissertation committee to seek approval to move forward with this process. The committee granted approval for the research pre-

proposal, and I was able to proceed with the pilot interviews. I also had IRB approval from LSU.

The pilot study allows the researcher to gain knowledge of information and events that are not anticipated, and possibly refocus and enhance guiding questions to improve data gathering. Sampson (2004) described the use of pilot studies in ethnographic and other forms of qualitative research as invaluable. Sampson (2004) further stated that conducting a pilot study prevents the researcher from spending too much time in an area that is not focused, and "facilitates the proper scaling and costing of a research proposal" (p. 399).

The pilot interviews proved to be an essential component to my study. I was able to enhance my guiding questions to better capture the lived experience of the new graduate nurses. I ultimately gained an insightful perspective of their experience as a new graduate RN working in an acute care hospital setting. I recognized that I needed to understand what prompted their interest to study nursing in the first place, and how their thoughts, perspectives, and expectations had changed, if at all. Enhancing my guiding questions provided more insightful interviews, and allowed me to gain a heightened awareness of the new graduate RN's overall experience. Ultimately, meaningful, detailed interviews were obtained that contributed immensely to data analysis. I was able to use all of the pilot interviews in my study, with the exception of one.

Population and Sample

Qualitative research sampling strategies are purposeful, where the researcher has reasons for selecting specific participants, events, or processes

(Rossman & Rallis, 2003). In this study, purposeful selection of individuals who were practicing as new graduate baccalaureate-prepared RNs working in acute-care hospital settings were targeted. Qualitative research does not typically have large sample sizes. In this phenomenological study, I interviewed eight individuals, which rendered hours of data from which themes were derived. After careful and thorough review of the transcripts, I determined that saturation was reached, and data collection was terminated. According to Munhall (2001), saturation occurs when all levels of codes are complete, and when no new conceptual information is available that indicates the need for new codes or expansion of existing ones. New descriptive data may be added; however, the information will not be useful unless the theoretical codes need to be altered. When all the data appropriately fit into the established categories, “interactional and organizational patterns are visible, behavioral variation is described, and behavior can be predicted” (Munhall, 2001, p. 233). By repeatedly reviewing and asking questions of the data, the researcher can be confident that data collection is complete, and ultimately a sense of closure is achieved.

RNs were defined as an RN who had graduated from an accredited baccalaureate nursing program and had passed the National Council for Licensure Exam for Registered Nurses (NCLEX-RN). Furthermore, the RN had been working in an acute-care hospital setting from three months to one year. This time period was selected because it provided the new RN an opportunity to be oriented to a new facility and become somewhat acclimated to their new job. Participants were selected from three major acute care hospitals located in a

large southeastern Louisiana city. Three hospitals were used in order to gain perspective and insight from RNs working in different facilities. After explaining the purpose of the study to nurse managers of acute care settings, the names of new graduate baccalaureate RNs were provided to me.

I contacted the RNs by phone and asked them if they wanted to participate in the study. Confidentiality was ensured, and I informed them that the interviews would take place away from the hospital. Every new graduate nurse that I contacted wanted to participate, but one was going out of town and I was unable to get back in touch with her. All subjects met the criteria of being within three months to one year of practice. Once it was determined that they met the criteria for the study, I talked with my major professor and we agreed that they would be appropriate to interview.

Data Collection

Human rights protocols from Louisiana State University (LSU) were followed for the study. Written application was submitted to the Internal Review Board (IRB) of LSU. An IRB exemption 2712 was filed and granted by the university. There were no physical, sociological or psychological risks involved to the subjects who participated in the study. In addition, subjects received no monetary compensation for participating in the study. Once written approval was granted from LSU, the process of data collection began.

In order to ensure confidentiality, subjects were not identified by their name or social security number. A fictitious name was given to each participant so that the researcher was able to refer to the subject in data analysis and

reporting. All participants received the consent form and cover letter that explained the rationale and purpose of the study prior to beginning the interview. The consent was signed, and any questions that the participant had were answered prior to beginning the interviews.

When determining where to conduct the interviews, several options were discussed. Because the interviews took place away from the hospital in which the participants were employed, all but two of the interviews were conducted at my place of employment at the School of Nursing. One exception to that was the first interview, which was conducted in a conference room of the public library, but I did not find this environment to be warm or conducive to interview process. The room was impersonal, and I wanted the participants to feel comfortable throughout the interview process. Therefore, by mutual agreement between me and the participants, the other interviews took place at my office or in a conference room at my work at the School of Nursing. I initially had concerns about conducting the interviews at the School of Nursing, because I did not want the participants to feel like they were returning to the student role or view me as a teacher. However, those concerns were quickly alleviated by all of the participants, who expressed comfort in meeting with me at my office. This setting proved to be much more inviting and warm, and conducive to interview. The other exception was an interview with a participant who lived out of town. She drove in to work every day, and we agreed to meet at my house which was a half-way point between her work and home.

My office is set up with the chairs adjacent to each other, and my desk is not between myself and the participant. The desk faces the window, and there are many nursing and family pictures throughout. I closed the door for all interviews to ensure privacy. Some of the interviews took place in a small conference room across from my office because the office temperature in my office was too cold to be comfortable and relaxed. That room has a large desk surrounded by several comfortable chairs. It has several nursing themes on the bulletin board, and is very inviting and warm. I sat next to the participant without the desk separating us.

The interviews were audio tape-recorded in order to ensure that data was accurate and complete. I did not take notes during the interviews, because I wanted my attention completely focused on the participants. I maintained field notes before and after the interview. The field notes were updated while transcribing, which assisted me in gaining better insight and understanding of the lived experience of the new graduate RN.

I transcribed the data in my home using my laptop computer. My home was completely private, and confidentiality was easily maintained. I found that transcribing the interviews was an essential part of the research process, because it allowed me the opportunity to revisit the interview, and single out details that I may have initially overlooked. I reviewed and reflected upon the transcripts numerous times until I was satisfied that detailed and complete data was obtained. The transcripts were sent to my major professor for her input, and we met numerous times to review our thoughts. I also sent a copy of the

transcripts back for the participant to review, clarify, add, or delete any of the interviews. The member check served as an opportunity for research credibility, with is equivalent to validity in quantitative research. Data was triangulated by providing a copy of the transcripts to other master's prepared RNs to determine research dependability, or reliability. The purpose of triangulation is to be assured that the same findings and themes were consistently identified by them. One member check was conducted by a Nurse Practitioner who has over 20 years of nursing experience, including as a nurse educator. The other member check was done by a master's prepared RN, who has 20 years of nursing experience. The last five years has been as a nurse educator. In addition, my major professor reviewed all transcripts and provided her insight.

The audio tapes were kept in my home locked up in a closet. My major professor and I were the only individuals who had access to the tapes. The audio tapes will be kept locked up in my closet at home for three years. After that time they will be destroyed.

Instrumentation

The Role of the Researcher

In qualitative studies, the researcher serves as an instrument (Marshall & Rossman, 1999). Observing the participant throughout the interview assisted me in gaining insight into the RNs' experience. I maintained field notes describing the participant's verbal and non-verbal behaviors. As the interviewer, my role was to use guiding questions to facilitate discussion and generate thought in an environment that the participant felt comfortable to express his or her thoughts.

I have been an RN for 20 years. Twelve of those years have been as a nurse educator, with extensive experience interacting with new graduate RNs. As a new graduate RN working in an acute care hospital setting, I can recall the feeling of being overwhelmed. The patient load, responsibility of caring for human life, and lack of support were daily realities. As a nurse educator, I continued to recognize this among the new graduates who were working on acute care units. I could often sense their frustration, and the struggle of wanting to provide excellent patient care while trying to manage the day. I have often felt powerless when working with them, and have had an acute interest determining how this experience and transition could be more positive and effective.

Direct observation of the participant during the interview was critical. It enabled me to make notes about areas that were of greater concern or seemed to be more effective to the participant. I initially recorded my thoughts by paper and pen, but later transcribed the field notes into Microsoft Word software. This experience assisted me in better understanding the new graduate's role, and ultimately assisted in complete data collection. I maintained detailed field notes to help gain understanding of the behaviors exhibited during the interview. Observations made were correlated to each other, with an attempt to develop themes and categories. This process continued until themes and patterns were identified.

Guiding Questions

Guiding questions were used to assist the researcher in obtaining data. The guiding questions were generated based on an extensive review of the

literature and from experience I have had as a Registered Nurse and nursing instructor. Qualitative inquiry enables the researcher to consider any information in the area being studied, as long as it is acknowledged as a possible bias. The questions were adjusted after the initial interview in the pilot study, which helped me to refocus and redirect the questions. The guiding questions were:

- 1) What made you decide to become a nurse?
- 2) Do you enjoy being a nurse?
- 3) What made you decide where to work after graduation from your baccalaureate nursing program?
- 4) What were your feelings about beginning your job as a new RN in an acute-care hospital setting?
- 5) Did your feelings about your new role change after starting your job? In what way(s)?
- 6) What does it mean to you now to be a RN in an acute-care hospital setting?
- 7) What are the primary concerns that you have experienced as a new RN in an acute care hospital setting?
- 8) What would you consider to be the primary stressors in your new role?
- 9) What do you consider to be the most important factor(s) that would contribute or did contribute to your success as a new RN?
- 10) What do you like most about working as a new RN in an acute-care hospital setting? Least?
- 11) What could have been done differently or more effectively in assisting

you in becoming acclimated to your new role?

Management of the Data

Data analysis took place by a phenomenological approach described by Moustakas (1994), which was a modified version of the Stevick-Colaizzi-Keen method. This method begins with a full description of one's own experience of the phenomenon. The researcher then finds statements from the interviews about how the individuals are experiencing the topic, listing out significant statements. These lists are referred to as horizontalization of the data, with each statement treated as having equal worth. The researcher works to develop a list of non-repetitive, non-overlapping statements. The statements are then grouped into meaningful units, with the researcher providing detailed description and verbatim examples. The researcher then reflects on her own description and uses imaginative variation or structural description. All possible meanings and divergent perspectives are sought, varying the frames of reference about the phenomenon, and constructing a description of how the phenomenon was experienced. An overall description of the meaning and the essence of the experience are then constructed by the researcher. This process is followed first for the researcher's account of the experience, and then for that of each participant. From this information, a composite description is written (Moustakas, 1994).

The one-on-one interviews rendered hours of data from which themes were ultimately derived. I personally transcribed the audiotapes verbatim into a Microsoft Word document. I saved all transcripts in a file which helped to

organize the considerable amount of data. Field notes were also maintained in a Microsoft Word file that I updated immediately after the interview and throughout the transcription process.

In order to analyze the data, I read and reread each transcript, giving equal worth and value to all statements. I reflected on each interview, attempting to look beyond the obvious content and gain insight into the lived experience of each RN. As I read each transcript, I made notes of similar themes, words, or concepts that evolved. I found that rereading the transcripts and reflecting on the content served as an invaluable means to identify themes.

Ethical Dilemmas

As a nurse educator, the possibility existed that a new RN may have been taught in the clinical setting by the researcher. I tried to avoid this because of any bias that may be present that could possibly affect the interview. Some of the participants were graduates of the school of nursing where I am an instructor. However, this did not prove to be a problem, as I did not have any preconceived notions about the RNs as students. As the researcher, I had to be cognizant of the role as investigator and avoid any temptations to offer advice or guidance to the new RN. All efforts were made to protect their confidentiality and ensure that they were aware of all aspects of the study.

CHAPTER 4

ANALYSIS OF THE DATA

The purpose of the study was to explore the lived experience of new graduate baccalaureate Registered Nurses (RNs) who work in acute care hospital settings. My phenomenological study focused on eight new graduate RNs who worked in three different hospitals in a mid-sized metropolitan south Louisiana city. These nurses participated in interviews with researcher-developed guiding questions to generate thought and inquiry. The interviews were audiotaped, transcribed verbatim, and reviewed numerous times for data analysis and emerging themes. The guiding questions were:

- 1) What made you decide to become a nurse?
- 2) Do you enjoy being a nurse?
- 3) What made you decide where to work after graduation from your baccalaureate nursing program?
- 4) What were your feelings about beginning your job as a new RN in an acute-care hospital setting?
- 5) Did your feelings about your new role change after starting your job? In what way(s)?
- 6) What does it mean to you now to be a RN in an acute-care hospital setting?
- 7) What are the primary concerns that you have experienced as a new RN in an acute care hospital setting?
- 8) What would you consider to be the primary stressors in your new role?

- 9) What do you consider to be the most important factor(s) that would contribute or did contribute to your success as a new RN?
- 10) What do you like most about working as a new RN in an acute-care hospital setting? Least?
- 11) What could have been done differently or more effectively in assisting you in becoming acclimated to your new role?

This chapter will introduce the reader to each participant, and data analysis will be discussed. Textual descriptions from the participants will be used throughout this chapter to support the findings and assist the reader in gaining insight into the lived experience of each participant.

Participants

The Registered Nurses who were selected to participate in my study had been practicing within a three month to one-year time frame in an acute care hospital setting. This time frame was selected because it enabled the new RN to have become acclimated to their new role. In addition, all of the RNs had passed the National Council Licensure Exam for Registered Nurses (NCLEX-RN). Prior to beginning all of the interviews, the participants read the cover letter and signed the consent. I answered any questions that they may have had, and always felt the need to reinforce confidentiality. I wanted all of my participants to feel that they could speak openly of their experiences, and be assured that their identity would be protected. None of the participants had any concerns about proceeding with the interviews.

Sarah

Sarah was the first RN that I interviewed in the pilot study. It was conducted in July 2004 at a large public library. Sarah graduated in December 2002, but did not pass the NCLEX the first time. She decided to take some time off before beginning work, passed the NCLEX, and actually started working in October 2003. Sarah had been practicing as an RN for 10 months and worked on a very busy 30-bed medicine floor.

I conducted the interview in a conference room in the public library. The room was large and private, but very impersonal. It had long tables surrounded by wooden chairs that were fairly uncomfortable. The shelves were lined with research books for genealogy, and were essentially utilitarian. I had concerns that the lack of warmth in the room could possibly impair the interview. Although my concerns were ultimately unfounded, I had already decided that I would not conduct any more interviews in that environment.

Sarah was a very confident RN who had adjusted well to her new role. She answered questions honestly, and expressed her concerns relating to her job, such as getting new admits throughout the shift. However, after closely examining the interview transcripts and after a lengthy discussion with my major professor, I recognized that some enrichment to the guiding questions were necessary. Although my guiding questions provided me with data, I realized that I needed to have the RN reflect on the reasons that the nursing profession was selected. Therefore, I enhanced my guiding questions to provide for a richer, more in-depth interview to gain a better understanding into the lived experience

of the new graduate RN. In addition, shortly after the interview, Sarah left the hospital and state to pursue other endeavors. I was, therefore, unable to reach her to conduct member checks of the transcripts. After collaborating with my major professor, the decision was made not to include this interview in data analysis because of concerns about the interview environment and the need to enhance the guiding questions.

Michelle

Michelle worked on a busy telemetry unit. She had a previous degree in animal science and had returned to earn a bachelor's degree in nursing. Michelle had previously lived in another state, and had moved because she planned to marry soon and her fiancé lived in this area. She had many new adjustments, including a new city, hospital, profession, and an impending wedding.

After talking with Michelle, the decision was made to meet her at my office. However, we moved to a small conference room adjacent to my office because my office temperature was too cool. Michelle graduated in May 2004, and began working in early June. The interview took place when Michelle had been working for four months, in a small conference room at the School of Nursing. Michelle is soft-spoken, intelligent, and very respectful. She often responded to me with "yes ma'am," a quality that is reflective of her rich southern heritage. I initially had concerns that she might not be comfortable participating in the interview; however, these concerns were unsubstantiated, because we had an open, easy rapport throughout the interview.

Michelle worked on a telemetry floor. She expressed concerns over her short orientation period, which was three or four weeks instead of eight, as she was promised. Michelle stated that she often felt overwhelmed by the patient load. While in school she cared for two patients, Michelle is now responsible for seven patients. Although the nurse-patient ratio was especially stressful, Michelle felt that she did have some support working with her preceptor. The preceptor assigned to work with Michelle was very helpful, and she felt comfortable asking her for help.

Michelle stated that she was very nervous, but excited about her new role as an RN. However, she worked 12 hour shifts, and would leave exhausted “both mentally and physically.” Michelle would often cry over the stress of her job, but would return the next day because it was “like an obligation that I just had to. And it had to get better—I just couldn’t quit.”

Other stressors that Michelle identified included working with doctors, administering medications in a timely manner, and the constant anticipation that a patient’s condition could deteriorate and ultimately “code.” She pointed out that she had not yet had Advanced Cardiac Life Support (ACLS), but felt that this training would be of value and possibly alleviate some her anxiety about running a code. However, it was the nurse-patient ratio that Michelle expressed concern over numerous times. She constantly worried that she did not get to see all of her patients enough during the shift.

Michelle felt that her unit manager was helpful, and she was comfortable approaching him for any concerns. She worked 12-hour day shifts, which she

was glad because she was afraid that working nights would “mess up your sleep.” Michelle credits the staff on her unit with helping her transition into the RN role. She was also comforted when she learned that other new graduate RNs who had been practicing a little longer had experienced the same stressors.

Michelle believes that working on a medical unit such as telemetry is only temporary for her. While working on this type of unit has been invaluable for the experience, she would prefer working on a Labor and Delivery unit or a critical care unit, where the nurse-patient ratio would be considerably smaller. Figure 1 summarizes Michelle’s experience as a new graduate baccalaureate-prepared RN working in an acute care hospital setting.

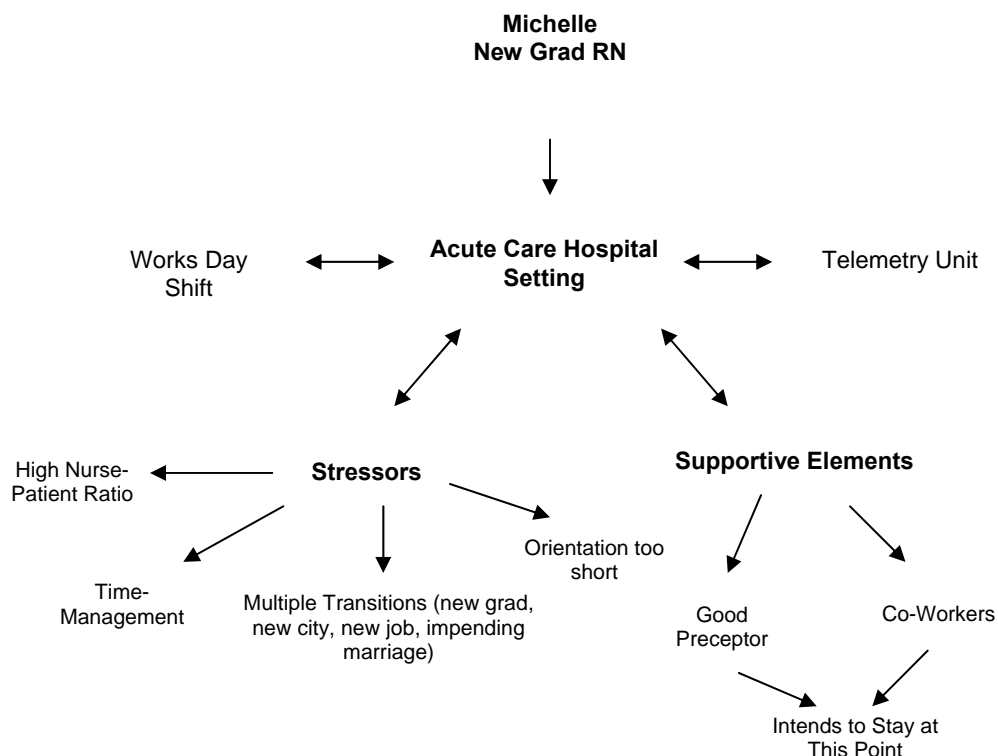


Figure 1. Representation of Michelle’s experience as a new baccalaureate-prepared Registered Nurse working in an acute care hospital setting.

Robert

Robert graduated from nursing school in May 2004, and our interview took place when he had been practicing for four months. He had no prior degrees, but had spent several years as a hospital corpsman in the Navy. I met Robert in the small conference room at the school of nursing. The room was private, quiet, and we had no interruptions during the interview. Robert is very pleasant, and we had a very good rapport. He laughs easily, and tends to make others feel comfortable in his presence. He understood the purpose of the study, and was very happy and willing to participate. Robert is very easy going and enjoys talking. He was eager to share his experience.

Robert worked in a community hospital on a busy unit that provides care for pediatric, cardiac, and telemetry patients. He had been employed by that hospital in the lab while he was in school, and they offered him financial incentives to work for them as an RN. The financial motivation was of great importance to Robert. The hospital offered to pay back 85% of his college student loans; however, that has yet to transpire. This has been very discouraging to Robert, since one of the main reasons he chose this hospital was because of the financial incentives. Because the hospital has not lived up to their end of the agreement, Robert does not plan to stay past a year. Robert also lives in the community, but was willing to go to other facilities because of salary.

The experience that Robert gained in the Navy was of great value to him. Although he was nervous about beginning his new job, his Navy background helped tremendously with his role transition. Robert states that being an RN

means being able to take control of a situation. However, unlike working in the lab, he now has to interact with management and deal with the low morale of other staff members. While the unit is supposed to be primarily cardiac, there are many medicine patients. Robert states that he was not aware of that when he interviewed for the job, and really would have preferred not working on the floor. However, he recognized the importance of gaining the experience on that type of unit, and intends to use this time as a stepping-stone to other job opportunities.

Robert works nights, and states that the hours are very grueling. He works nights by choice for the extra pay and to be away from the managers and physicians who are there predominately during the day. The lack of experience was voiced by Robert many times during our interview. Although he may not want to ask for help, he does so readily because of patient safety. Robert expressed concern about the orientation period to his new job, which was one month instead of two, as he was promised. Robert had support from his co-workers, but was very careful who he approached for help and who he avoided. Robert also expressed concern about the hospital layout and environment. He stated that many patient rooms are far away from the medicine cart, supply rooms, and nurse's station. This makes for extra walking and ultimately wastes valuable time that could be devoted to patient care.

There were several stressors that Robert identified, including interacting with physicians and dreading the possibility of a patient coding. The nurse-patient ratio can be as high as seven to one at night, and this can be extremely stressful when the patients are very sick. Although he prefers working nights, it has made

it difficult with his wife and children. Figure 2 summarizes Robert's experience as a new RN.

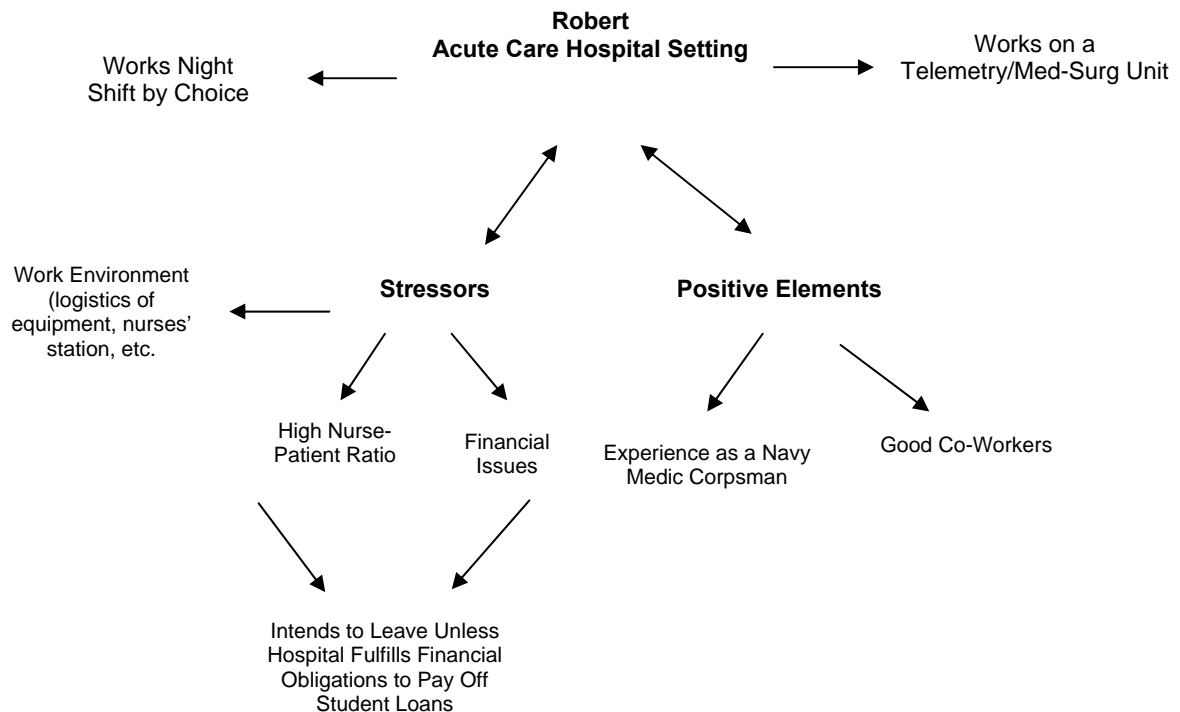


Figure 2. Representation of Robert's experience as a new baccalaureate-prepared RN working in an acute care hospital setting.

Mary

Mary graduated from her Baccalaureate nursing program in May, 2004. We agreed to meet at my office for the interview, which took place when Mary was in her fifth month of practice. The interview was uninterrupted, and the office was quiet and warm. Mary readily agreed to participate in the study, and we established an easy rapport throughout the interview. She passed the NCLEX, and had been working for four months. Mary is a very articulate, intelligent young

lady, who is clearly committed to her patients. This is her first degree and first nursing job.

Mary began working on a busy 30-bed medical-surgical nursing unit. She selected the hospital because of its reputation, and the unit because of the atmosphere that she noticed during her interview. The manager was very open about the problems on the unit, and how they were working to make things better. Mary had fears and concerns about working on an acute care floor. The nurse-patient ratio was higher than that of a specialty unit, and Mary was aware of that when she accepted the position.

Mary works nights, and her usual nurse-patient ratio is seven to one. Although she started on days, the rapid turnover and excessive paperwork were making it difficult to become acclimated to her job. Mary stated she would “put off” the necessary paperwork in order to concentrate on providing care for her patients. Because of the fast pace of the unit, Mary felt that her patients were getting the care that they needed, but not to the extent that she wanted to provide. She readily acknowledges that time management and prioritizing has been a problem. Because working nights has fewer staff members, management, and physicians, Mary felt that this environment would be more conducive to her learning.

Mary oriented to her new job for approximately two months. She stated that she had an additional week and a half to orient to other roles, such as the computer system and working with the charge nurse and unit clerk. Although these activities were helpful, Mary felt that the time would have been better spent

working with her preceptor on the unit. Mary had two preceptors with whom she oriented on the unit. Working with two different people gave her the opportunity to see two different views on how to work. Mary learned that she was off of orientation when the new schedule came out, and quickly asked for more time because she did not feel ready to work on her own. She was given an additional week and a half, and then went on her own. However, Mary does not feel that the orientation period was long enough, but when she was working independently, she just “got it done somehow.”

Mary states that her co-workers are helpful, and she is comfortable approaching them for help. However, sometimes she feels like a burden asking so many questions, but she believes that those concerns are her own perception. As Mary began practicing independently, she stated that it was actually difficult for her to say that “I’m a nurse.” Now when she says those words, Mary feels a huge sense of accomplishment and responsibility. While it was overwhelming at first, Mary states that she is now more comfortable with being a nurse.

Beginning her new job brought many new stressors. Mary stated that working with doctors was intimidating, especially at first. Although this is getting better, she sometimes feels “clumsy” while assisting with procedures. Mary also identified time management as a stressor, and expressed concerns that she was not assessing something that she should be. Although Mary finds the possibility of omitting important assessment concern, she is learning from her experiences.

Mary stated that a very important part of her RN role is serving as a patient advocate. Patients often feel helpless in the hospital, and Mary believes

that the RN can be of great value advocating for patients while they are sick or having surgery. Mary also considers being knowledgeable about medications and pathophysiology an important part of being a RN. She often asks other RNs to validate a finding if she is concerned that something is not right with her patient. Mary states that she felt a “little bit overwhelmed” when a patient’s condition began to deteriorate. Although she has not had one of her patient’s code, it is something that is always on her mind. However, Mary is comfortable about the staff support she has when a code situation occurs.

Mary finds it difficult to leave work at work. She finds herself thinking about work all of the time, and would like for this to improve. At this time, Mary is planning to work on the night shift for a few more months. She hopes to continue to improve her time management and become better acclimated to the hospital environment. Mary originally thought that she would stay on the unit for a year, then transition to the emergency room. However, Mary states that she likes her unit and enjoys being responsible for her patients. Figure 3 summarizes Mary’s experience.

Michael

Michael had been practicing for one year after graduating from a baccalaureate nursing program. He had passed the NCLEX on the first attempt, and had not changed his place of employment. Our interview took place in the conference room at the school of nursing where I am employed, and the room was both quiet and private. Michael signed the consent for participation, and I

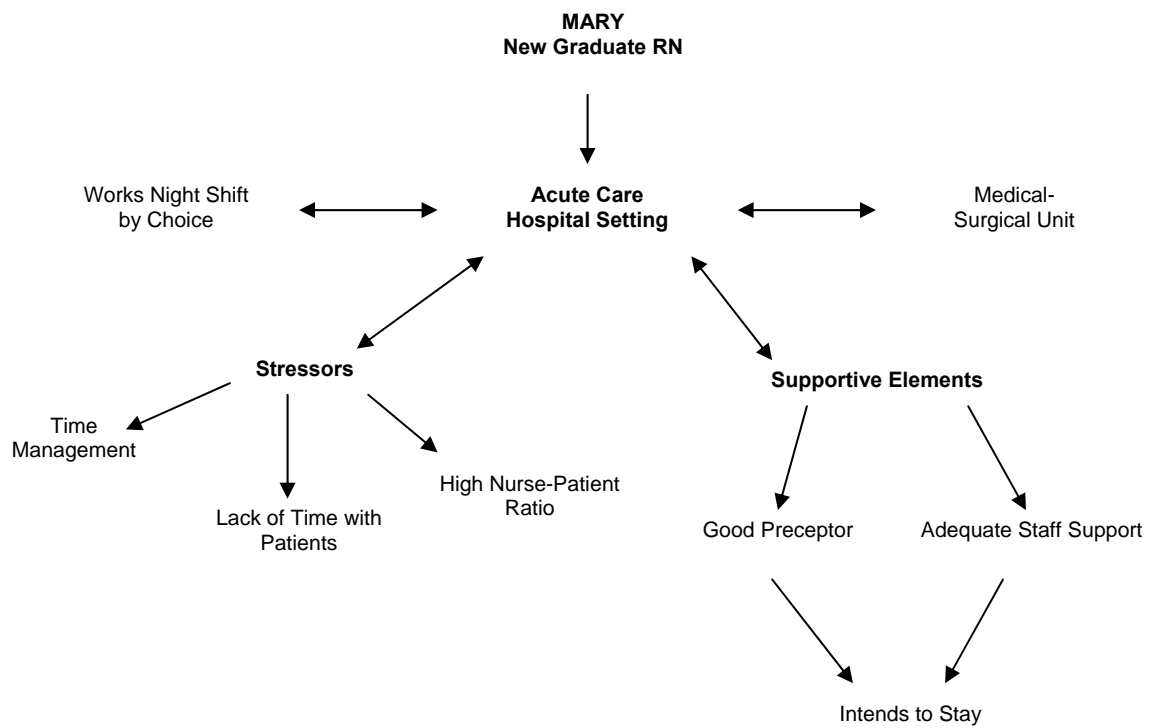


Figure 3. Representation of Mary's experience as a new baccalaureate-prepared RN working in an acute care hospital setting.

reassured him of confidentiality. The interview was audiotaped, and Michael was glad to participate in the study. We had an open, positive interview, where Michael was honest and willing to share his experience. Michael is a mature, insightful, and quiet young man who is extremely intelligent and easy to talk with.

Michael stated that his desire to become a nurse stemmed from his Christian faith and desire to help people. There were no other nurses in his family. Michael enjoys being a nurse, but stated that while some days are very rewarding, other days are very stressful. He works on a 20-bed telemetry and medicine unit, which he described as an overflow unit. The hospital's reputation of being a "good place to work" helped in his decision to being practicing there.

Prior to beginning employment, Michael stated that he was "real nervous," but very excited. He recognized that there would be a big learning curve, given that he did not know anyone or anything about the facility. His decision to work on a telemetry unit was originally going to serve as a foundation to pursue ICU. The excitement lasted through his six weeks into orientation, and then Michael stated that it was "pretty tough" working on his own. The orientation period was positive, because although his unit was in transition with limited experienced nurses, his preceptor had over five years of experience as an RN. One reason that Michael chose to work nights is because of the experienced nurses on the shift.

Michael stated that his preceptor shared more than clinical knowledge. He also learned from her the hospital organization and other information unique to the facility. While he felt more confident at the end of his six-week orientation,

Michael did not think that the orientation period was long enough. His orientation experience also consisted of time learning the computer system, but not enough time learning about the facility. The overall time in orientation that was caring for patients was about five weeks. Michael believed that the preparation time of learning the facility, computer, and CPR (cardiopulmonary resuscitation) should be separate, and not considered a part of orientation with patient care. Although he was unable to put a number on how long orientation should be, Michael stated that a couple of more weeks may have been helpful. A more gradual approach may have been of value.

Once Michael was out of orientation, he was “still very excited, but also very nervous.” He was primarily nervous about things that were out of his control, such as a code situation. Michael was dreading having a patient code, or even sending a patient to ICU. The patient population on the floor is much more acute than he feels it should be, but Michael believes that his experiences as a nurse has made it less intimidating than when he first started.

Should a code situation arise, Michael has good support. His co-workers are more experienced than other shifts, but even he was put in charge one night just six months after graduation. He felt that it was potentially a dangerous situation, although everything ultimately worked out. However, Michael expressed concerns about staffing issues, specifically when a nurse is sent home because of what initially starts out as a low patient census. Patients are then admitted, with only half of the staff available to care for the patients.

Michael works 12-hour weekend nights, Friday, Saturday, and Sunday by choice. He now works as charge nurse when needed, and has had the opportunity to charge when the regular charge nurse is there to help. The unit manager is supportive, but Michael describes an on-going conflict between house supervisors and unit managers. Staffing is of greatest concern, where the unit managers want no more than a six to one nurse-patient ratio, but the house supervisor will allow seven. Six patients are the norm, but the number of admits or the possibility of a patient's condition deteriorating makes that number somewhat stressful. Michael believes that four or five patients would be a safer number.

Michael states that being “overwhelmed with someone to take care of that you’re really just kind of making it through the night” is most stressful. In addition, interacting with physicians, especially at night, is unnerving. While he was initially intimidated in dealing with physicians, he is now much more comfortable. Michael had not yet taken ACLS, but he stated that he was scheduled to take it within a month of our interview.

Michael is proud to be an RN. He describes nursing as a “tough job,” and did not anticipate it to be as physically demanding as it actually is. However, Michael likes being there to care for his patients. He enjoys “being able to do good,” and states that it is very rewarding. Initially, Michael dreaded going to work, but now that has improved. He believes that this has improved as he approaches the end of his first year in practice. Michael prays for everything to

go well before he gets to work, but still feels “horrible” when he is not able to provide the care that his patients deserve because of inadequate staffing.

Six months down the road, Michael plans to still be working on the same unit. While he initially planned to pursue ICU, Michael states that he no longer wants to do this. He is going back to school soon to become a nurse practitioner, because he is interested in primary care. Overall, time has made his job satisfaction improve somewhat. As he reflects over the past year, he states that he was planning to quit at the six month point. However, “it was really my own growing in the profession,” his improved comfort levels, and consistent staffing that have prompted him to stay. Figure 4 describes Michael’s experience as new RN.

Jane

Jane graduated from her nursing program in December 2003, but did not begin work until April 2004. She had passed the NCLEX on the first attempt, but was unsure of where she wanted to work. Because Jane commutes into work from another city, we agreed to meet at my home, which was a mid-point between her work and home. We met in January 2005, when Jane had been working for nine months. It was cold and rainy outside, but my home was warm and relaxing. I initially had concerns about meeting at my home, but those concerns were unfounded. The home setting served as a quiet, private environment, with no interruptions. The consent was signed, and the interview was audiotaped. Jane is a very intelligent, philosophical young lady. We had an excellent rapport, and Jane talked openly and passionately about her experience. She works on a very

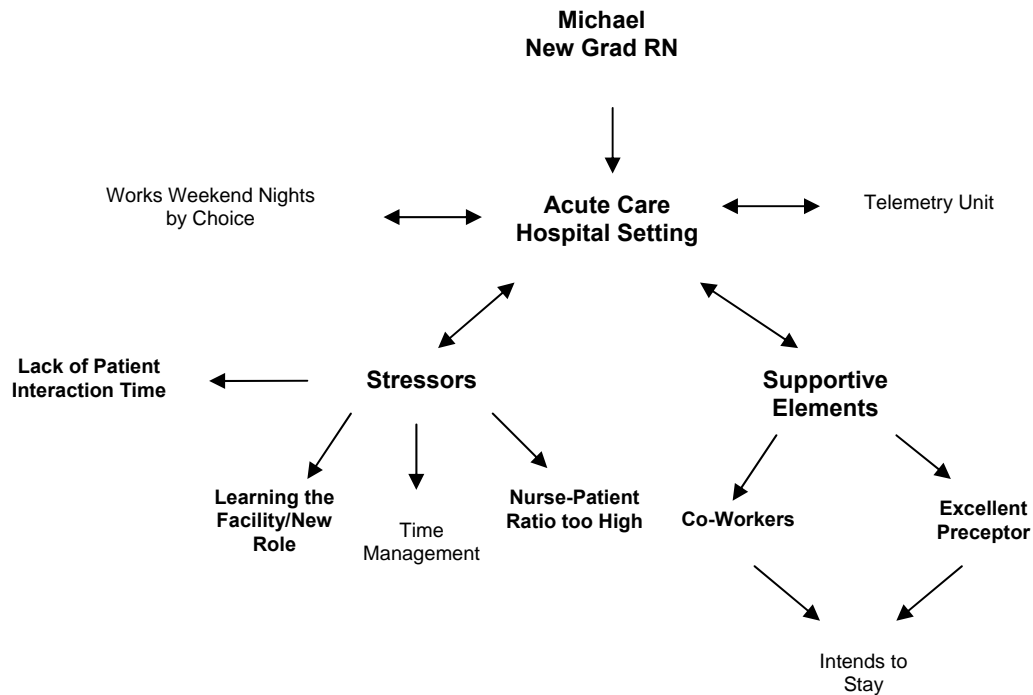


Figure 4. Representation of Michael's experience as a new baccalaureate-prepared RN working in an acute care hospital setting.

busy 30-bed telemetry unit, which serves as the foundation for her story.

Jane selected the hospital and Telemetry unit because she enjoyed both caring for the elderly and cardiac patients. The hospital was selected because she had done many of her clinical rotations in that facility, and found the staff to be very receptive to students. In addition, she liked the fact that it is considered an education hospital. Jane drives in from out-of-town to work in this facility, when she could have worked in a hospital closer to her home.

Jane studied nursing because of her love of both science and people. She considers the family to be an important extension of the patient, and enjoys spending time with them. Jane likes being a nurse, and builds a good rapport

with her patients. Caring for her patients is a deeper experience, which Jane describes as “it’s an investment into someone else.” In addition, Jane considers her profession from a Christian standpoint, where her faith is stronger and she can provide the kind of care that God would want her to give. While Jane thoroughly enjoys caring for her patients, she describes the hospital setting as the challenge. She stated, “It’s not just as simple as taking care of your patients.”

Prior to starting her new job, Jane was anxious and excited. She was anxious about working independently, and excited to have accomplished her goal of becoming a nurse. Being a nurse makes Jane feel proud and good about herself. However, after she started her new job, Jane’s feelings about her new role began to change. She had an eight week orientation with an excellent preceptor, but knew that her confidence level needed to increase. Jane wanted her patients to trust her and be comfortable with her knowledge level. The stressors, however, were primarily prioritizing and learning the overall unit environment and facility.

Although Jane’s orientation period was scheduled to be eight weeks, she was put on her own a little earlier because both her manager and preceptor felt that she was ready. Her orientation period was seven weeks, but she did not get some of the experiences that the new nurses now receive. Working nights, working with the charge nurse, unit clerk and telemetry tech are now a part of the orientation period. Jane agrees that new nurses should have these experiences, but not as part of the eight weeks with the preceptor. She feels that this should

be time in addition to the eight weeks, providing a longer, more comprehensive orientation opportunity.

Jane works the day shift, and feels comfortable going to certain nurses for help. She stated that not all nurses were receptive to questions, and would make her feel “stupid for asking questions.” In addition, Jane has questioned the ethics and judgment of some of the nurses, which troubles her deeply. She prefers to seek help from those who would care for their patients as she would. If a patient’s condition is changing, Jane is very comfortable asking someone to validate her assessment findings. She continues to learn from all of these experiences. Jane also believes that working nights should be included in the orientation period, because it allows the RN to see how the hospital runs on a 24-hours basis. She is still open to having the experience of working nights so that she can have a better understanding of the continuity of care.

Communicating with doctors is “nerve-wracking.” Jane’s preceptor helped her with preparing to call physicians, and now she often consults the charge nurse to validate the need to call. She is not, however, comfortable approaching her unit manager. The manager is over two very busy units, which makes her often unavailable. In addition, Jane feels that there is favoritism among certain nurses, which deeply disturbs her. Because of this, she is uncomfortable voicing her concerns.

Jane plans to leave the unit when she reaches the one-year mark. She would like to work in a specialty area such as ICU. The nurse-patient ratio on her unit is six to one, and she feels that she is unable to spend adequate time with

her patients. Jane stated that “pretty regularly you just feel like overwhelmed,” and this has not gotten any better. This becomes even more frustrating if a patient’s condition begins to deteriorate. Although she gets help from the other nurses, she worries about her other patients while she is busy with the patient who is not doing well. However, the experience of caring for patients whose condition is deteriorating has increased her confidence. But Jane readily admits that she will call a code without reservation if she believes that a patient is going into respiratory or cardiac distress. Jane has not yet had one of her patients die, but “that’s still a fear for me.”

The primary concerns that Jane experiences on her unit are lack of camaraderie among the nurses and staff and lack of resources, including staff. Jane describes herself as running, and “you feel like you can’t give your patients the quality care that they deserve.” In addition, “you pray that you do the best that you can.” Jane says that she has learned to cope better by just knowing that she has done the best that you she can, and by acknowledging that “things aren’t going to change.” The nurse-patient ratio is a stressor for Jane, and she says that she goes home exhausted. Jane adds that while the nursing shortage is a problem, management is also a factor. She recognizes the importance of all staff members in the hospital as integral to providing excellent care. Patient care assistants are not always readily available, which increases the frustrations. However, she stated that “we need to give nurses less patients so that they can do more of the patient care assistive roles, or get you help. And fight for their cause because they do a lot of work.” You cannot do it all by yourself, which is a

reality that Jane has begun to accept. Jane's experience as a new RN is summarized in Figure 5.

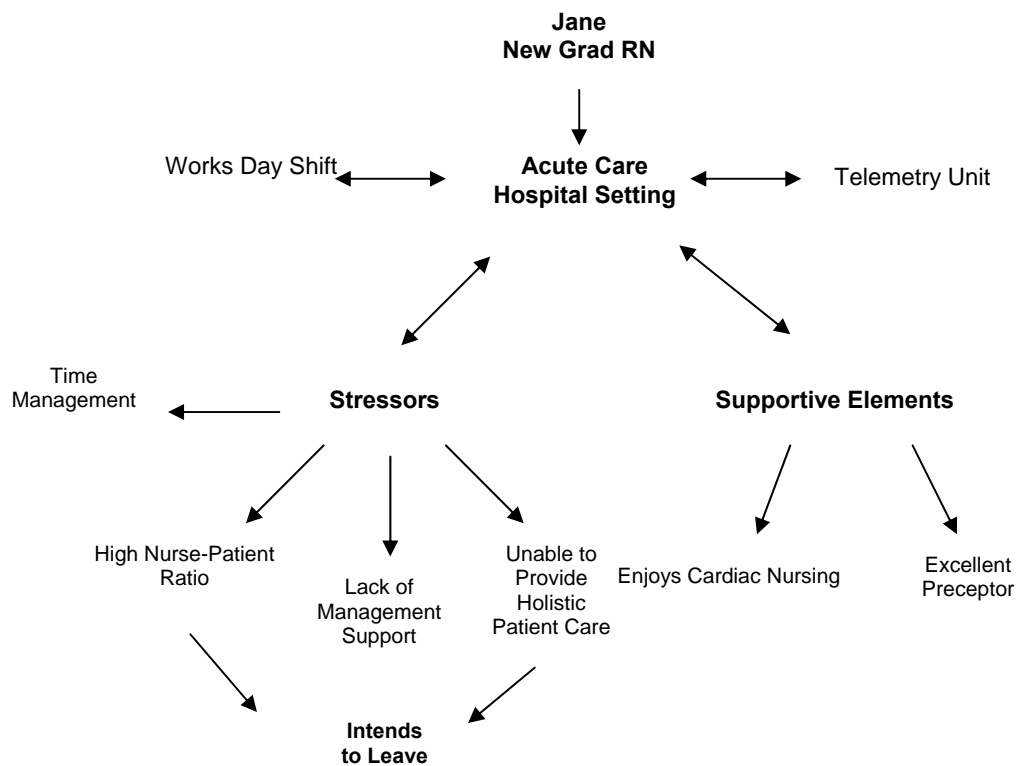


Figure 5. Representation of Jane's experience as a new baccalaureate-prepared RN working in an acute care hospital setting.

James

James graduated from nursing school in December 2003, and had been practicing as an RN for one year when we met for the interview. We agreed to meet for the interview at my office at the School of Nursing, which was convenient to his home. My office was quiet and private, with no interruptions. James is a very enthusiastic, energetic young man, who is also kind and compassionate. He is talkative and eager to share his experiences as a new RN.

We established an excellent rapport, and James talked openly and honestly about his journey. James works on a very busy medical surgical floor in a large, south Louisiana hospital, where he has been employed since he began practicing. However, the primary patient population is those who have undergone surgery.

James is the only child to parents who had him later in life. While he was a freshman in college, his mother suffered a stroke and subsequently died. The experience of caring for his mother prompted him to become a nurse instead of an attorney, which was his original plan. James likes being a nurse, but stated that he is beginning to get burned out. Because of this, he is planning to leave the acute care hospital setting and work in home health. This is James' first degree, and his story centers on what has led him to this point.

James had previous experience working at the hospital before he began practicing there as an RN. Prior to starting his job, James said that he was "petrified." While he did not feel as though he was being thrown to the wolves, he recognized the significance of having the responsibility of individual's lives in his hands. James was both excited and nervous about starting his new job, to the point where he was nauseated. However, once he started working on the floor his feelings began to change. James initially worked the evening shift, but now primarily works days.

It was quite a surprise to James, that as a male nurse, he might be treated differently. Although he enjoyed helping others, James was repeatedly called upon to assist with lifting and transporting patients. This bothered him because

despite the fact that he had the same or higher education, he was the one who was asked to help. Another issue that was extremely distressing was some racial comments that were made by both patients and other nurses. He also had to deal with those who made the assumption that because he was a male nurse, he was homosexual, which he denies. James handled these episodes with professionalism, but it continued to bother him. In addition, James worked with many associate degree nurses, who often made comments relating to his higher educational level. Again, he says "I just try to over look it." James further states "...but you know, pressure will burst a pipe. And I think that's what's happened to me now." He feels that he is at his breaking point.

When James first started his job as a new RN in an acute care hospital setting, he was excited to go to work. Now, however, he hates to go to work. He attributes this to his unit and co-workers. James stated that he always had the first admit, and he tended to have the largest patient load. On a given day or night, James' nurse-patient ratio is seven to eight patients to one. James claims that this is not safe, and has great concerns about his patients. When help is needed, he initially goes to the charge nurse, most of whom are very helpful. They have also been helpful when a patient's condition deteriorates. James worries about the possibility of a patient coding, and was concerned about being blamed for something going wrong. However, when he does get into an emergency situation, he responds calmly and without hesitation. Afterward, James stated, "Oh my God, I can't believe I did that!" although he hopes it does not happen again, he is proud that he was able to function well and help his

patient. If a patient dies, James says that he gets very emotional. He has empathy for the family, but does not receive support from staff. James states that this has further alienated from his co-workers.

James was in orientation for about eight weeks, and he thinks that time period is too short. He believes that at least four months would better prepare a new nurse to safely care for patients. James feels that the ideal safe and manageable nurse-patient ratio would be five to one. Once there are more than six patients, he does not have the time to talk with his patients, which he greatly enjoys. James does not have any problems interacting with doctors. He feels that as long as he is correct in his assessment, the physician's response does not matter. The aspect he enjoys most about working in an acute care hospital setting is the fast pace and the patient population.

James is devastated by the lack of staff support, and perceives this as a primary stressor of his job. He is actually changing jobs, and will be working at a different facility in the home health department. Other jobs within the hospital were pursued, but James believes that his manager blocked the transfer because of the serious staff shortages on the unit. He feels very sad about leaving under such strained conditions, because he truly loves the facility. Concerns were also expressed about hospital administration. While they claim to understand the stressors of working the floor, James believes that they do not have a true feel for what is going on. Greater insight by management might help the overall environment on the floor. As our interview concluded, James

expressed sincere appreciation for the opportunity to share his story, and hopes that it will someday help others. Figure 6 summarizes James's experience.

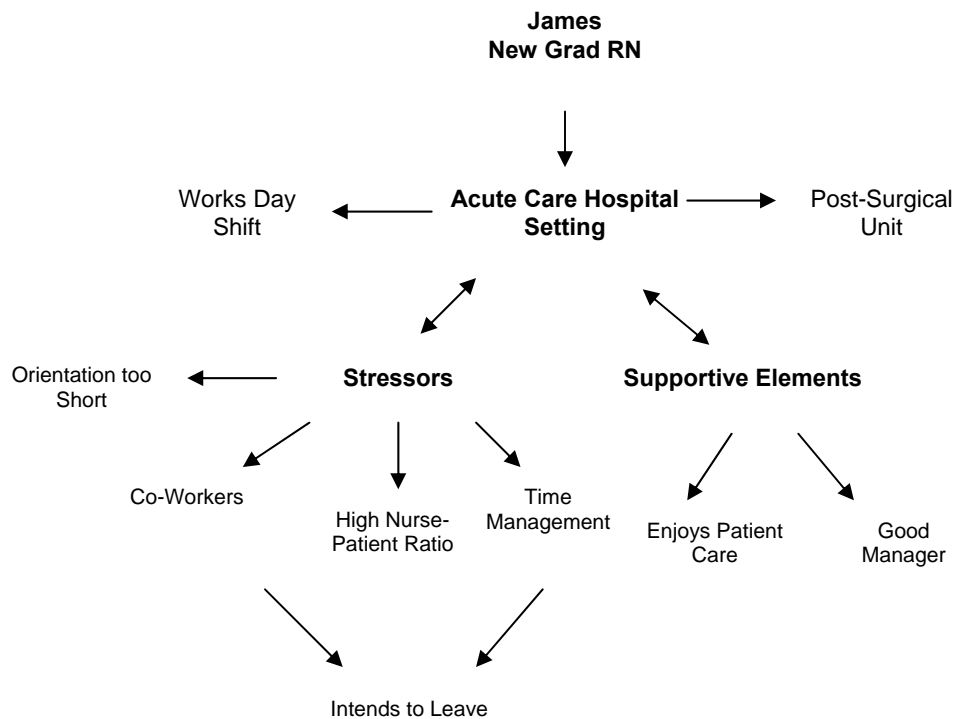


Figure 6. Representation of James's experience as a new baccalaureate-prepared RN working in an acute care hospital setting.

Anna

Anna graduated from nursing school in May 2004, but did not pass NCLEX on the first attempt. While she had worked for a short period of time before she received her state board results, she took a break when she failed in order to study and rest. Anna passed the NCLEX on the second attempt, and had been working for three months when we met for our interview. She is employed on a very busy 30-bed medical floor, which was a different facility from

her original employment. Anna decided to become a nurse because she was interested in science, and her grandmother encouraged her through the years. In addition, salary was an incentive to enter the profession. Although Anna signed the consent and was willing to participate in the interview, she seemed tense. Her non-verbal responses indicated that she was stressed, but Anna wanted to share her story. The interview was audiotaped, and confidentiality was reinforced. We met in my office at the School of Nursing, which was quiet and private. There were no interruptions throughout the interview.

Anna chose to work at her present hospital because she had done clinical rotations there while in school. She thought that she would be most comfortable working on a medical-surgical floor, without any telemetry monitored beds. Before beginning her new job as an RN in an acute care hospital setting, Anna was nervous, but not really excited. Her main concern was primarily about taking seven patients. Other concerns were about all of the other details that were “behind the scenes,” such as admit paperwork, and taking off orders. Anna describes herself as being a “nervous person in general.” Her preceptor was travel nurse, who left before Anna was out of orientation. She was placed with another preceptor, but was only on her schedule for two weeks after orientation. The orientation period was six weeks, with two weeks of caring for seven patients. Anna did not feel this was long enough, but did not say anything to her manager. During her orientation period, she was supposed to work for four hours with the unit clerk, but did not because “she’s not nice.”

Anna works 12-hour night shifts by choice. She refers several times to caring for seven patients, which clearly distresses her. I asked Anna about that, and she expressed concerns about her time management. She likes to have her charting done on-time, and gets worried if she gets behind. Most stressful, however, is the on-going worry that something could go wrong with one of her patients. The charge nurse can help, but it is difficult because he has his own patients after 11 p.m. Anna thinks that five patients would be more manageable and safe. Now that she is the RN caring for her patients, she feels “kind of good, but I’m thinking in the back of my mind, they don’t know that I just graduated.” The majority of the nurses on her shift are fairly inexperienced. There is a Licensed Practical Nurse (LPN) to whom Anna asks for help, but she is somewhat disorganized. Her charge nurse is now telling her “it’s your call” when she asks for any input.

It is important to Anna to validate the need to phone a physician, especially during the night. She does not get overly anxious about calling the resident physician on-call, but may question the need to call a private physician. Residents seem to be “a little bit more understanding.” The hospital that Anna worked in for a short time after she graduated was very small and less stressful. They were unable to re-hire her after she did not pass boards because there was no longer a position there. Anna’s ultimate goal is to eventually work at that hospital when a position becomes available.

Although Anna has not had a patient code, she worries about it all of the time. She states that she will call for help without delay. While Anna has had a

patient die, it was expected. Anna is more concerned about an unanticipated emergency. She stated, "You're worried about the sudden death." Anna stated that she has had some problems dealing with a pharmacist, which has caused her considerable stress. As she discussed this, she became clearly distressed, and became quiet for a while. I allowed Anna to collect herself, and we began to talk about this more. Anna feels that this has contributed to her stress, and plans to discuss it with her manager.

Anna stated that she is unhappy at work, which is causing extra stress with her husband. They would like to start a family, but Anna has health insurance with her job, and she has concerns about getting pregnant while she is so unhappy with her job. Her ultimate plan is to re-evaluate her job in six months, and "then I don't know what I'm going to do from there. I mean, it may get better, but it just doesn't seem like it." Anna would eventually like to work in wound care, which would require extra schooling. At this point, she is just trying to get through the night. Anna's experiences are summarized in Figure 7.

Researchers Description of the Experience of the Phenomenon

Prior to each interview, I tried to clear my thoughts and enter each meeting with an open mind. I tried to be extremely cognizant of my role as the researcher, and not as an educator or Registered Nurse. I was initially concerned about the boundary of researcher, educator, and nurse, but I found this to be less difficult than I had anticipated. Although memories of my own experiences as a new RN always lingered in the back of my mind, I was able to listen to each participant

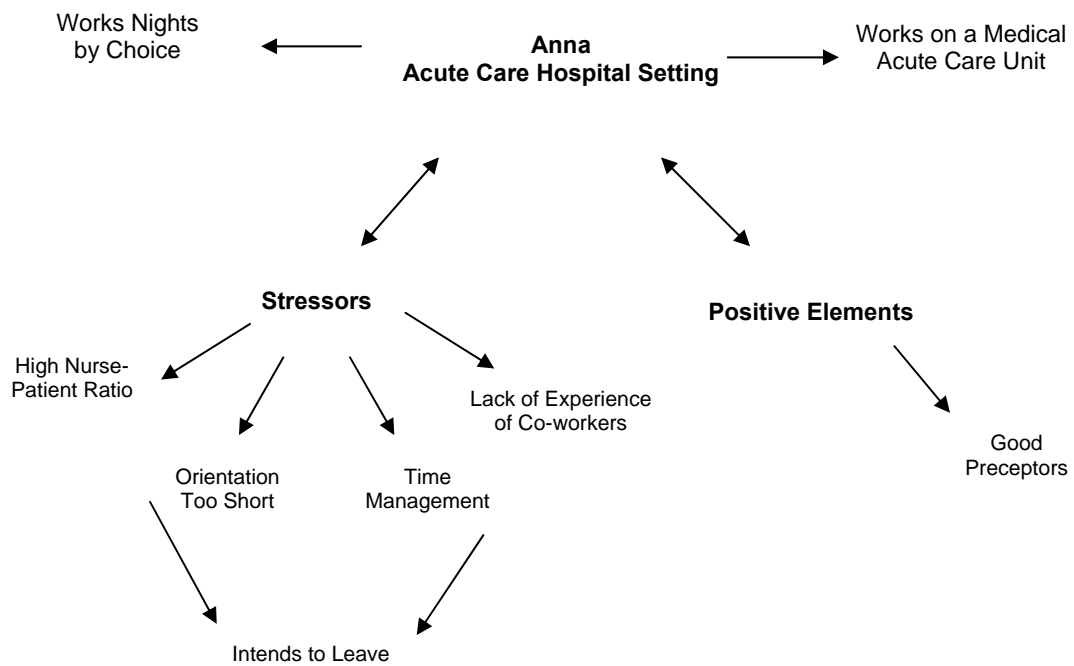


Figure 7. Representation of Anna's experience as a new baccalaureate-prepared RN working in an acute care hospital setting.

intently and ultimately capture their story. The interviews with the participants were each unique and insightful. I could feel the excitement of each new nurse, and sense their frustration as they became aware of stressors and barriers that they encountered. Of greatest interest to me was the tremendous commitment to patient care that each participant expressed in a fierce, passionate manner. Their reasons for entering the nursing profession were clear, and their intense frustration with encountering the barriers that prevented them from providing the excellent patient care was apparent.

I was often moved by the sheer emotion expressed by the participants. Many times I wanted to offer support and advice, but restrained myself from doing so because of my researcher role. While many of the participants considered practicing in the acute care hospital setting as a stepping-stone to another unit, others would stay given the right circumstances. It was a powerful experience, and I was extremely grateful to all participants who so openly and honestly shared their stories. Each participant had a story to tell, and as it unfolded I found myself amazed at the resilience and commitment that each had to the nursing profession and their patients.

Horizontalization of the Data

I considered each statement with respect to significance for description of the experience. All relevant statements were recorded. Non-repetitive, non-overlapping statements were listed, which became the invariant horizons or meaning units of the experience. After carefully reading and re-reading and reflection of the transcripts the following horizons were identified:

- Why they entered the nursing profession
- Why the hospital or unit was selected
- Feelings about starting their job
- Primary stressors identified
- What has helped with the transition
- What does it mean to be an RN in an acute care hospital setting
- Intent to stay or leave the acute care unit

Reduction and Elimination

Each grouping was carefully considered and repetitive data was synthesized and extraneous data was eliminated. Each statement was considered to determine if a moment of the experience was necessary and sufficient for understanding the phenomenon. What remained were the invariant constituents of the horizons.

- **Why they entered the nursing profession**
 - Help people
 - Christian calling
 - Experience with ill family member
 - Enjoyed science
 - Previous experience in medical profession
 - To be a part of the patient and family's lives
 - Encouraged by family members to study nursing
 - Loves people

- **Why the hospital or unit was selected**

- Previous work experience at the facility
- Lived in the area
- Promised financial reimbursement to assist with student loans
- Reputation of the hospital
- Environment of the clinical unit while on the interview
- Was on the unit as a student

- **Feelings about starting their job**

- Excited
- Nervous
- Nauseated
- Worried about the responsibility of caring for human life
- Concerned about telling the patient the wrong thing
- Worried about the learning curve of the facility, unit, and responsibilities
- A deeper experience and an investment into someone else
- Petrified
- Had definite reservations, especially because it is known that working med-surg is hard work and nurses get burned out
- Felt like they needed the med-surg experience

- **Primary stressors identified**

- Orientation period too short
- Preceptor not on their shift after orientation

- Having other activities during orientation that decreased time with patient care
- Nurse-patient ratio too high
- Not enough time to spend with patients and serve as a patient advocate
- Lack of resources
- Manager not involved enough
- Time management
- Medication administration and time constraints
- Time management
- Prioritizing
- Co-workers
- Concerns about a patient coding
- Interacting with physicians
- Not knowing the right answer
- Working the day shift and the extra staff (physicians, management, administration)
- Lack of experience of other nurses on the unit
- Problems delegating
- Concerns about a patient dying, especially unexpectedly
- Having a situation that they are not prepared to handle
- Conflicts between unit manager and administration
- Asking for help

- **What has helped with transition?**
 - Working nights
 - Having a supportive and knowledgeable preceptor
 - More time in orientation
 - Supportive manager
 - Good charge nurses
 - Experienced nurses on the unit
 - Working as a tech or previous employment with the hospital
 - Time and experience
 - Dealing with residents was easier than dealing with physicians in private practice
- **What does it mean to be a new RN working in an acute care hospital setting?**
 - Being responsible
 - Being a patient advocate
 - Hopes the patient or family does not know lack of experience
 - Feels good
 - Feels proud
 - “Weird power over someone—you’re the one making the decisions”
 - Professional
 - Big accomplishment
 - Was difficult to initially say “I’m your nurse”

- **Intent to stay or leave the acute care unit**

- Already has another job
- Plans to give it another six months
- Wants to go back to school
- Wants to go to ICU
- Wants to be a nurse anesthetist
- Waiting for another job to open
- Would stay if student loans were paid off

Clustering and Thematizing the Invariant Constituents

After carefully reviewing the invariant constituents, the themes were identified. These are the core themes of the experience of the participants as a group. Textual and structural descriptions were used to support the findings. Each theme will be further discussed, with supporting verbatim text from the transcripts to better understand the findings.

- **Why the participants entered the nursing profession**

This question was added after the first two pilot interviews, after I recognized the importance of the RNs reflecting on this aspect prior to beginning the questions relating to their present experience. There were a variety of reasons that the participants expressed for entering the nursing profession. Many of the participants had the common theme of wanting to help others.

Mary stated that “I’ve always had a little bit of the mothering thing and the caring thing, always...and then I’ve always loved science...”

Michael: “I wanted to help people basically, and care for them in their time of time of need.”

The combination of the love of science and people were a driving force for some to enter nursing. Jane had a deeper description of why she entered the nursing profession:

Jane: "I always loved science and people...I found that nursing was the best way for me to help people and actually be a part of not just the patient but the family...I felt like I had an investment in their care."

Anna: "I am just interested in science. It was about the only thing in school I was interested in, so, nursing, that's what to study. I went in that direction."

James and Anna had reasons for entering nursing that were family related. Anna was strongly encouraged by her grandmother. James was the son of older parents, and it was his experience of caring for his ill mother that led him to the nursing profession. Of interest were Robert's reasons for becoming a nurse.

Robert: "I never wanted to be one [a nurse]. Then, all of a sudden it came. Well, I was in the military, and we worked under the nurses. And I said, I'm not going to be a nurse, I don't want any part of them. I didn't want nothing to do with them. But my original plan about why I became one is crazy...I don't know, I think about it now."

Jeannie: "What? What was it if you don't mind sharing?"

Robert: "No, you see, my grandmother was a nurse."

Jeannie: "An RN?"

Robert: "Yes, and she was like over the public health unit in [names city]. She started that up. "

Robert was truly influenced by his grandmother, despite the fact that he was adamant about not being a nurse while in the military. James entered nursing after his mother became ill and subsequently died.

"...I became a nurse because my mother had a stroke my freshman year at [college]. I wanted to be an attorney, and I became a nurse because my mother died...that is what gave me the drive to become a nurse."

Michael and Jane believed that as Christians, they were led to help others.

Michael: "...I'm a Christian, so I really feel that I've been called to do that and serve in that capacity."

Jane: "...I try to look at it from a Christian standpoint. I feel like it's made my faith stronger, and that I can give care of, you know, God would want me to give care."

- **Why the hospital and unit were selected**

I felt that it was important to determine why the participant chose to work on their respective units because it provided insight into why they were working on an acute care type setting. Various reasons were cited by the participants, but the reputation of the hospital was important to some. In addition, previous experience in the hospital or on the unit as a student or worker served as an influence.

Lindsay: "...the [hospital] had won Louisiana state Hospital of the Year for three years in a row...so I thought that was a pretty big honor for a hospital to get that three years in a row."

James: "When I was in high school I was in COE, cooperative office education, and my job was at [names hospital]. And I really, really enjoyed the hospital."

Anna: "...I had been there before [while in school]."

Robert had worked at the hospital while he was in school, and they offered him financial incentive to work there.

"...they promoted this thing where you worked there for three years, and on the internet for the government to pay back 85% of your loan. But no one's gotten it yet. And they promote it all the time. Everybody that's been there a year before me that's signed up for it and still nothing's happened or heard anything."

Robert was extremely concerned that his loans would not be paid off, and the

promise made would not be fulfilled. Michelle moved to the area from another state, and her fiancé lived in the community of the hospital that she selected.

- **Feelings about starting their job**

Most of the participants were both excited and nervous about starting their new job as an RN in an acute care hospital setting, but for different reasons.

James was excited, to the point that he was sick.

James: "I was very excited. I mean I'm telling you like, I'm the type when I get excited, I'm nauseated and vomit. I was like that about a week before I was going to work. I was very excited."

Michelle: "I guess I was kind of nervous just thinking that I wouldn't recognize if something started to go wrong. I didn't know if I knew enough."

James: "I was extremely nervous. I was extremely nervous. I had to take my Bentyl and Phenergan and all those pills before I went (we laugh). I'm serious! I'm serious. I was very excited about working."

Jane: "Anxious. I thought it would be different because I was a nurse now, and I had gone through clinical and pleased all of my instructors and done anything to their specifications, it was a different nervous...I was excited. That I had worked so hard and come so far and actually achieved my goal from being a student to professional."

Anna: "I was nervous, just starting out...just not really knowing everything. Just kind of being thrown out there...and I'm a nervous person just in general."

Mary: "Definitely some reservations, just because it's known that med-surg and acute care in the hospital is very hard work, and that's where a lot of nurses get burned out..."

For some of the participants, the reality of caring for human life impacted their feelings about starting their new role. They were worried about saying the wrong thing to their patients.

Jane: "These feelings centered around taking good care of my patients and a bit fearful that my patient would have a detrimental problem that I didn't feel ready to face on my own as a new nurse."

Robert: "I feel good. I just feel a little, you know, shy about telling people what is wrong."

Feelings changed for many of the participants once they started their job.

Robert: "I don't know, it was kind of like, 'Why did I do this?' What did I get myself into?"

Jeannie: "OK, tell me more."

Robert: "...I felt like that at the time because at the time when I was just working in the lab here, I didn't care what was going on, I just did my little job and I was gone. But now you have to intermingle with all the different, uh, I guess management. And all the different personalities and things like that."

Robert later talked more about his initial feelings about starting to practice as an RN.

Jeannie: "So, when you started, you said, 'Why did I do this?'"

Robert: "Um hmm."

Jeannie: "All right, let's go back to that for a second. Ok, do you still feel that way?"

Robert: "No, I'm better now since I kind of know a lot of the stuff that's going on and how to do certain things."

Jeannie: "So, what do you think changed?"

Robert: "I guess doing it over and over and you finally get comfortable with it."

Jeannie: "Experience?"

Robert: "Yes."

Jeannie: "So, now you work...what kind of unit is it?"

Robert: "Well, it's supposed to be a pediatric and cardiology/telemetry unit, but most of the people who come in there they don't put on telemetry, so they're there for medicine."

Jeannie: "Did you know that before you started?"

Robert: "No, I figured it was going to be cardiology unit."

Jeannie: "Is that what you wanted?"

Robert: "Uh, I really didn't want to work on the floor. "

Jeannie: "Ok."

Robert: (laughs) "I didn't want to work there."

Jeannie: "Ok, tell me why."

Robert: "I don't like the hours and I don't like...well, it wears you out. All that 12-hour constantly on your feet if it's busy. You know, it wears your body out and I don't know, it's just not what I wanted to do."

Jeannie: "What did you want to do?"

Robert: "A more specific job."

Jeannie: "Such as...."

Robert: "Well, I was thinking nurse anesthetist. Uh, OR [operating room], uh, anything that was more specific instead of all-around."

Jeannie: "But you ended up on the floor."

Robert: "Yes."

Jeannie: "Because why?"

Robert: "Because I needed the experience, a year experience before I could ...they won't accept you until you do."

Jeannie: "OK, you said they said 'I needed the year experience.' Did you feel the same way?"

Robert: "Yes. I said I know I've got to do it, so I could go on. Because if I went straight to a more specific job I wouldn't have been able to catch all that other stuff. Like in school, you go through it and you learn about

everything—most everything, and as you get out if you don't do it it's just going to go away. You're not going to have it."

Jeannie: "It's back there, but you're not using it."

Robert: "Yes. I still do that now."

Jeannie: "Ok, tell me about it."

Robert: "Well it's like things they're talking about—I've heard of it but I don't know what it is."

Jeannie: "What do you do when that happens?"

Robert: "I ask them to explain why, or I can go look in a book and try to figure out what it is."

Jeannie: "What kinds of things are you talking about? Give me an example...."

Robert: "Well, just different procedures that these people might be going through. I know like things like EGD and stuff, but at first I was thinking, 'what is that?' Because I've always heard it as another name."

Jeannie: "So what is an EGD?"

Robert: "Well camera goes down your throat to look at the gut."

Jeannie: "And so, when you started hearing these things..."

Robert: "Well, like if it was in report and they started to mention this, and I'd just write it down and go ask them."

Jeannie: "So how'd you feel when you were like, 'What is that?'"

Robert: "I should not be here!! (laughs) I was like, maybe I'm not the safest person here right now."

Michael had concerns about things that were possibly out of his control and not knowing what to do about it.

Michael: "I was still very excited, but also very nervous. And more worried about things that were beyond my control. Like, for instance, coding. Things like that that I hadn't had any experience with."

Michelle described her experience in detail. Her new role was also mentally and physically draining.

Jeannie: "So you really had kind of mixed feelings. You were really excited that you were a nurse."

Michelle: "Um hmm."

Jeannie: "... about starting this new role in life. OK, after you started your job, did your feelings about your new role change? And if they did change, in what way(s) did they change?"

Michelle: "I mean I knew what all a nurse had to do, [but] it was just like 12 hours just flies by. It's just a lot. I would be exhausted when I left there, both mentally and physically."

Jeannie: "Tell me more about that. Mentally and physically exhausted...what did you do about it?"

Michelle: "I would just cry every day for the first week at least. Maybe one and a half. I did not like it at all."

Jeannie: "When you were feeling that way, you were crying or feeling real stressed, what did you do?"

Michelle: "You mean like after I got home?"

Jeannie: "Even when you were going to work the next day. What made you get out of bed and go to work the next day?"

Michelle: "I guess it was like an obligation that I just had to. And it had to get better—I couldn't just quit."

Jeannie: "Is there anything that could have made it better for you?"

Michelle: (quiet for a second) "maybe just like one day having just three patients instead of seven. I mean, I don't know--It's just stressful. I guess that's just how it had to be. Now I'm just used to it. But..."

Jeannie: "What is the standard patient load?"

Michelle: "I think it's five to six people per nurse. But if they have a shortage...they do try to get people in if they can, but sometimes they just can't. You know it helps out not just to come say that I that they tried."

However, the word that all of the participants used in some capacity was “overwhelmed.”

Michelle: “I guess it was just overwhelming at first.”

Mary: “...just when, you know, ten things seem to happen at once, and you know, someone’s on the phone for you, a doctor wants you in this room, someone calls for pain medicine, somebody needs this, an IV is beeping, you know, things like that, you know, can get a little overwhelming, and you question can I handle all of this.”

Michael described his experience:

Jeannie: “When you were learning that role, what was one of your more stressful things that you can think of?”

Michael: “Learning to be just a nurse? A staff nurse?”

Jeannie: “Yes. Or as an RN.”

Michael: “As an RN. One of the most stressful things was really what I’ve been talking about. Basically, being so overwhelmed with someone to take care of that you’re really just kind of making it through the night. You’re not really—I mean, you’re learning, but just barely getting stuff done. It’s just, you know, being behind all night. Being stressed out. “

Jeannie: “Were you overwhelmed?”

Michael: “Oh yes. I have [been] before, certainly. Certainly, when you’re getting a whole bunch of admits, two are coming up at a time. Things like that are just real tough to manage.”

- **Primary stressors identified**

There were many stressors that were identified by the participants, and the stressors tended to be common among all of them. The orientation period was too short for the new RNs, and many were pulled out of orientation early for various reasons.

Jeannie: “How did you know that it was time to go on your own? Was it decided for you or...”

Mary: "It was pretty much decided. Basically, the schedule came out and I was on my own, and I was like oohhh, wait a minute. I'm not ready for this yet. And they were able to fit me in about another week and a half of orientation."

Michelle: "...whenever I applied there and got the job they said that I would have like eight weeks of orientation, and I only had like three or four."

Jeannie: "OK. Why was that?"

Michelle: "I think they were just short-staffed. Cause like I know one day I came to work and they need a nurse and they just took me out of orientation. And then like Friday—that was a Tuesday, and that Friday I was back in orientation..."

Jane: "But my preceptorship was eight weeks and worked good. I really felt like I was getting acclimated to being a nurse on the floor and learning the unit."

Jeannie: "If you could go back and think about the time with your preceptor, would you say that eight weeks was plenty of time to step out of that and be quote unquote on your own?"

Jane: "Well, looking back on it I didn't get everything I needed out of my preceptorship, um that I should have. I was actually pulled out a little early."

Jeannie: "Why?"

Jane: "Because my preceptor and my manager felt that I was ready."

Overwhelmingly, the participants had great concerns about the nurse-patient ratio, and the ability to deliver safe patient care. Most of the new RNs cared for six to seven patients. However, when asked what a safe, manageable number would be, all participants stated that five would be ideal.

Jeannie: "How many patients do you have on a given night or day, on a normal day? What is your normal nurse-patient ratio?"

James: "Seven to eight."

Jeannie: "Is that safe?"

James: "No! Not for me. When I have eight patients all I'm able to do is pass medications. And it's not safe. I cannot be in eight places at eight different times. And these are fresh post-op patients...I'm running 12 hours. I'm not eating. I mean, you know, I'm pulled in eight different directions. I go for assistance. Sometimes I get it, and sometimes I don't."

Jeannie: "How many patients do you think ideally you could safely take care of? In any ideal situation, if you could pick a number, what would it be?"

James: "Five." (he states this without hesitation). Five. I feel that five is adequate enough for a registered nurse to go and do pushes [IV pushes], etc, etc, as well as my work. Six, I can do. Seven, I can do. Eight, I can do, but I'm not going to do more than eight. But I feel that ideally, five to six is a good number."

The nurse-patient ratio for Mary is six to one. She shared her thoughts about how that experience was introduced during orientation.

Jeannie: "When you were in orientation, did you take up to six patients?"

Mary: "By the end, yes."

Jeannie: "How long did you do that?"

Mary: "I think it was only a week. I think that actually what happened was I had taken up to three or four patients and it was the end of my orientation, or almost at the end, and I only had about a week left...the problem is not knowing what to do now, the problem is not knowing the medications or knowing what to do now, the problem is how do I do it for all of these patients at the same time. And after that, it was no more of OK, start with two patients, then the next week we'll take three and the next we'll take four. It was just, OK, you're going to have six tomorrow and from here on out."

Michael also discussed his feelings about the nurse-patient ratio on the telemetry unit.

Jeannie: "...about your patient numbers...on a normal night, how many patients do you usually take?"

Michael: "Oh, at least six. Usually. I mean, not at least, it's usually six at the most. But there have been times that I've taken seven with telemetry

patients. You're not supposed to have more than six telemetry patients, and there have been times where I have had telemetry patients and a seventh patient."

Jeannie: "How do you feel taking care of six patients?"

Michael: "...if I had six patients to begin with, it wouldn't be that bad. But, It's when you get all these admits. We can get five admits overnight, in an eight-hour period, which doesn't sound that bad—but, when you have just two other nurses, and the charge nurse has a bunch of patients herself, it will slow you down a lot."

Jeannie: "Ideally, if you could pick a number on a telemetry kind of floor like you've got, what do you think would be, I guess, safe?"

Michael: "Safe? Well, you know all it takes is one patient to be not doing well and you neglect everybody else. And that happens unfortunately a lot. But I think four or five would be a lot better than six. Certainly!"

Anna found the nurse-patient ratio especially stressful. She shared her experience about caring for seven patients.

Jeannie: "You mentioned seven patients a lot. Tell me more about seven patients."

Anna: "My time management is not up to par. Not nearly. I definitely know that. I'm just real—I like to have my charting done. And if my charting's not done, then I get real worried...with seven patients, like, I'm not always going to have all of my medications in my drawer, you know, waiting for me. So, I mean, just giving them at the right time just isn't going to happen, and I know it's not perfect every day, but it's still kind of..."

Jeannie: "What is it about seven patients that is the most stressful to you?"

Anna: "I mean, I just hope nothing's wrong with any of them."

Jeannie: "...what do you think would be ideal?"

Anna: "For the number of patients?"

Jeannie: "Yes."

Anna: "For me, I think five would be manageable and doable."

Jeannie: "From a safety perspective?"

Anna: "Yes, that, and time."

The nurse-patient ratio for Jane is six-to-one. She talks about this experience.

Jane: "A six-to-one ratio is very hard. And it's extremely even more strained when you don't have enough assistive help because you're dealing with six-to-one, and the PCA's (patient care associates) are having to deal with, they could have 15 to one. So getting a patient pulled up in bed may take 10 minutes, when it shouldn't take that long...you feel you can't get patients' needs cared for fast enough, you can't be efficient enough, and it's nerve wracking, because you know you're a really good nurse but you just can't do it all--because of the acuity on the floor—the involvement."

Another stressor identified was dealing with physicians. This was a concern for most of them, and they expressed this in the interview.

Jeannie: "What about those doctors?"

Robert: "I've only had one hang up on me."

Jeannie: "OK..."

Robert: "I don't know what's wrong with her—she does it to everybody though."

Jeannie: "How'd you feel when she hung up on you?"

Robert: "I just said, 'oh well.'"

Jeannie: "And you'd called her about..."

Robert: Well, I didn't call. Another one called and she had to go take care of something. I said, 'this is what she's calling for.' And she said, 'Ok, that's what's going on?' and I said 'yes', and it was just 'click.' And the next morning that same girl called her and she told her that, 'I need to tell you your patient fell.' You're supposed to tell them right when it happens. But she was like, 'you know, you could have waited a little later to call me.' And then hung up."

Jeannie: "And you..."

Robert: (adamantly) "I don't want to talk to them if they're going to act like that!"

Jeannie: "How do you feel about interacting with them. I mean, that's one example, but what about doctors in general?"

Robert: "The other ones I like—well, not all of them. But I don't know, it just depends on their attitude with things. They always have something to fuss about."

Jeannie: "Are you comfortable talking to them?"

Robert: "I'm getting better. At first, I didn't want to call them; I didn't want to say nothing."

Jeannie: "And just having to do it?"

Robert: "It got better. I tell them what I need, or what's going on with the person and what do they want to do..."

Michelle also expressed concerns about working with physicians.

Jeannie: "What about those doctors?"

Michelle: "Some of them are very nice. Some are not very nice. But, I mean, I guess that's just how they are. When I call and get an order, or whatever, they just talk so fast, oooww, I don't know all of the medicines, I have to get them to repeat it a few times. They talk so fast. But most of them are nice."

Jeannie: "So how do you feel if they get aggravated? (She makes a face) You don't like it?"

Michelle: "No! I mean, it's not that I, I guess I just take stuff too personally or something. You know, I don't like to be yelled out. Well, not yelled out, but talked to gruff or whatever."

Jeannie: "How do you feel when you have to call a doctor?"

Michelle: "I don't like it. It's intimidating."

Jeannie: "Is it?"

Michelle: "Yes."

Jeannie: "Is it getting any better?"

Michelle: "It is."

Jeannie: "Have you gotten to know some of the doctors?"

Michelle: "Uh huh. I at least recognize who they are. I guess not being from that area, I didn't know anybody."

Jeannie: "Well, that's true. Because you're not only new to the hospital, you're new to the whole area. That makes sense. So, when these doctors call, or when you have to call a doctor, and you have to get new orders, or whatever it is that they're trying to do. Do you – are you ever concerned— what are your biggest concerns?"

Michelle: "That they'll ask me a question and I'm not going to know the answer. I'll just feel stupid! You know, if they ask something simple, and I don't know it."

Jeannie: "How do you prepare yourself before you go and call a doctor?"

Michelle: "I try to have their chart in front of me, and their vital signs, and all that right there, so if they ask me and want that."

Jeannie: "Well, is there that could have been done different in nursing school that would have made that transition easier?"

Michelle: "I mean, I guess, we never called the doctors in nursing school."

Jeannie: "Were you prepared in nursing school to interact with doctors?"

Michelle: "Yes, but I guess in a small town, I guess I kind of knew most of them anyway."

Jane described her feelings about talking interacting with physicians.

Jeannie: "Let's talk about calling those doctors. Let's talk about those doctors."

Jane: "It's nerve-wracking."

Jeannie: "OK..."

Jane: "You get nervous. Whenever I was in my preceptorship and I had to call a doctor, and my preceptor was like do you want me to do it the first time so you can see how I do it. You can get on the other phone. And I was like, 'yes,' and that kind of helped me, um, just kind of hear a

conversation between a nurse and a doctor discussing a patient. A real live conversation. Not just of a one-end conversation.”

Jeannie: “You hear both sides.”

Jane: “Right. And before then, you’re still questioning your judgment about do I call the doctor about this, or do I not call the doctor about this.”

Jeannie: “And what do you do then?”

Jane: “I usually go ask. I’ll go ask my charge nurse, ‘Has so and so made rounds yet, I didn’t see him in my patient’s room. This is what I’ve got going on.’ You know, things like that.”

Michael shared his experiences dealing with physicians.

Jeannie: “...how did you feel as you, especially as a patient started going bad, and you need to find a doctor and that kind of thing. Is that stressful to you?”

Michael: “Oh yeah! Definitely. Especially at night time, because doctors tend to be more cranky at night (we both laugh), when you wake them up. Actually, I’m glad you mentioned that because that was one of the main things that out of school that I was worried about—calling the doctor at night time.”

Jeannie: “um hmm...”

Michael: “I felt comfortable talking to him. I knew what I wanted to tell him, but as far as just—I guess maybe it was just intimidation. I didn’t want to get chewed out, you know. But not now, it doesn’t matter. But as a new nurse, it did matter.”

Jeannie: “Have you been chewed out?”

Michael: “Oh certainly. Certainly.”

Jeannie: “How’d you feel?”

Michael: “Well, initially, it was kind of awful, but now it’s just like whatever. I mean, they get paid for that, you know, and I’m going to take care of the patient no matter what. Not matter if I have to wake them up or whatever.”

Jeannie: “So you’re much more comfortable with that now?”

Michael: “Oh, yes.”

Anna found that it was easier dealing with residents than physicians in private practice. However, it was still a concern.

Anna: "...I don't want to call the doctor 10 times during the night. Not if I don't need him."

Jeannie: "Ok."

Anna: "I've called him like twice before, and now it's three o'clock in the morning. You know, my patient gets two units of blood, and her blood pressure is 98/50...what do I do? Do I call him again, or do I just kind of monitor it..."

Jeannie: "What about talking to those doctors?"

Anna: "It really doesn't—calling them on the phone, it really doesn't bother me that much. I just hated to do it over and over again."

Jeannie: "Ok, it's three o'clock in the morning, and you know you need to call this doctor. Do you get anxious?"

Anna: "Not too much."

Jeannie: "Really?"

Anna: "Especially if it's one of the residents."

Jeannie: "OK, so you deal with a lot of residents in house. So you've got someone to call in house?"

Anna: "But they're not there for every patient. I don't mind them."

Jeannie: "What about another doctor who's not in house as a resident?"

Anna: "I kind of question it a little bit more, like, OK, I don't know if this doctor would get upset."

Jeannie: "Do you worry about them getting upset?"

Anna: "A little bit more than I would a resident. I don't know why, there's just something about it. But — they're younger, more understanding a little bit. I mean, really, if I need to call them, I'll call them."

Mary also had concerns about dealing with physicians.

Jeannie: "Let's talk about this for one second. Let's talk about those doctors."

Mary: "Um hmm."

Jeannie: "You told me that you have some doctors in your family?"

Mary: "My uncle."

Jeannie: "Ok. As a nurse now, as the nurse, how do you feel about working with doctors?"

Mary: "Um, at first I was a little intimidated, and now some of them, I still am a little intimidated. But you know the ones that you can approach and the ones you have to just stay away from. You know, let them to their job, and follow-up on it. But I think I've gotten much more comfortable communicating with them. Because at first I was scared to call the doctor for something."

Jeannie: "So now, your patient needs something and it's three o'clock in the morning."

Mary: "If it's three o'clock in the morning, I always question. I always ask the charge nurse would you call for this at three o'clock in the morning. And basically, it's usually a yes or a no—not even a question. So if she says yes, then I don't have a problem with calling."

James was overall comfortable dealing with the doctors. His view about interacting with physicians was very pragmatic.

Jeannie: "...What about dealing with doctors."

James: "I've never had a problem with doctors. All of my doctors are very nice to me, they're very helpful."

Jeannie: "Were you nervous about it at first?"

James: "At first. Because the nurses had me kind of scared to deal with doctors. You know, watch so and so, he'll tear your head off...I said well, you know, I'm a man, just like Dr. [Jones} is a man, and as long as I know I'm correct in my critical thinking skills and about my nursing skills, I'm not going to worry about it."

Many of the nurses were concerned about a patient coding and/or dying and not knowing what to do. They expressed their feelings about the on-going reality of a patient “going bad.” Mary described her experience.

Jeannie: “...let’s explore that a little more. Have you had a patient go bad on you?”

Mary: “Yes.”

Jeannie: “Like you’re in there one minute and they’re doing fine, and then you go back in there, and you’re like, something’s not right. So you pulled somebody else in.”

Mary: “um hmm.”

Jeannie: “How’d you feel?”

Mary: “Um, overwhelmed a little bit. I knew just by looking at him that something’s not right. He was breathing fine earlier, and now he looks like he’s struggling. I need to go, you know, assess him real quick, get a set of vital signs, and say, this is what I see. He wasn’t like this before. And because it was an airway kind of thing, I definitely had the help that I needed. Like two other nurses were in there and it was like, ‘OK, we’re going to do this, we’re going to do this, this is how we’re going to take care of it.’”

Jeannie: “So right away, you had help. Did you learn a lot from it?”

Mary: “Oh, yes.”

Jeannie: “Have you had more patients go bad since then?”

Mary: “Um, no, just some irregular things, not like it was life-threatening at that point.”

Jeannie: “Just atypical things that you had to address?”

Mary: “Yes.”

Jeannie: “Have you had anybody die while you were taking care of them?”

Mary: “No.”

Jeannie: "Ok. Have you participated in a code?"

Mary: "Yes."

Jeannie: "What are your thoughts about that?"

Mary: "ummmmm..."

Jeannie: "Because it's going to happen one day most likely."

Mary: "Yes. Um, I think like, I'd probably be the one to go and get supplies (laughs). They'd be like, we need this, and I'd be like, 'OK, let me go get it.'"

Jeannie: "Are you worried about it?"

Mary: "It's something that's always in the back of my mind."

Jeannie: "Is it?"

Mary: "Yes, it's always in the back of my mind. And you know, I think not so much knowing what to do, because there's always going to be someone there who is more experienced and can help me, so I don't think it would be a question of knowing what to do. I think it would just be the fact that this patient was fine earlier, and now look."

Michael also was worried about a patient experiencing distress.

Jeannie: "Well, let's talk about that—a code situation."

Michael: "Ok."

Jeannie: "Were you dreading that? Your first code?"

Michael: "Oh, definitely!! Oh yes. Even sending someone to ICU. I mean, I had done that in school before, but you know many times – all of those situations. The patients are much more acute than what they should be on the floor. That happens a lot unfortunately. And being a new nurse it's a lot more intimidating then if you were—well, now that I've been a nurse—I've been a nurse for a while it's not nearly as intimidating as it was when I first started"

Jeannie: "What were you most afraid of?"

Michael: "Um, really just having a situation that I wasn't prepared to handle. Like not knowing what to do. If I know what to do and I know how

to do it right, then I wouldn't nearly be as nervous. But it's the whole first time thing. You know, just not quite ready, where to go to, how to get ready to go, what's your role in a code. We talked about it, but it's like I guess I wouldn't be able to function."

James was actually concerned about being blamed if something went wrong with his patients. However, he feels that he is able to take charge of the situation.

Jeannie: "Well, let me ask you this...Let's talk about those codes."

James: "Ok."

Jeannie: "Your first code. Ok. How did you feel?"

James: "My very first code..."

Jeannie: "Or even before you even had a code. When you knew that any one of these patients at any point, something bad could happen. Do you worry about that?"

James: "Yes I do! And I look at it like, it will be—I'll be blamed. Such as, I had a patient, and I was still in orientation, this was my last day of orientation."

We talk briefly about something else, then returned to the topic of a patient coding.

Jeannie: "So it [his assessment] starts when you enter the room?"

James: "It starts when I enter the room. My assessment."

Jeannie: "Ok, well, you're in that room with the patient who is short of breath. And all of a sudden you see him kind of going down. You talked about that code situation. How do you feel?"

James: "I feel like I have to do something. When I get in an emergency situation, it's kind of like the calmness comes over me. And I'm like, do this, do this, do this. And then, I freak out afterward. So basically what I would have done in the situation with the patient having the shortness of breath. I would have tried, if the patient were on oxygen, I would have bumped it up. I would have tried to see; I would have run and gotten a pulse ox. I would have gotten vital signs..."

Jeannie: "How long did it take you to get comfortable with doing these kinds of things? Is that something that you've picked up?"

James: "No."

Jeannie: "Throughout your time working?"

James: "Oh, yes, yes. Most definitely. I learned—I mean, I got more comfortable the more situations that it happens. Like I said, that first particular time I had a code it was a carotid. She just went to have the carotid. So there's a [chance] they either go very good, or very quickly."

Jeannie: "When you say go, you mean go badly?"

James: "Oh yes. Go badly. The lady started with stridor [makes the sound], respirations went from 16 to 23. She was turning blue in the face. So we had a code. I went in there to look at her. The family was starting to get nervous. And I said, "Look I'm going to ask ya'll to step out of the room." Hit the code button, pushed the call light, got the crash cart down here. Pt. wasn't breathing good. The doctor just happened to be up here. The doctor ran up, and I had to take the patient down to MICU (medical ICU). She made it. The next day, my first day out of orientation, a family member coded at the elevator. He was 17 years old, an African American male, had a rare heart disease. There was no one near. He fell out, coded, he was in asystole (flat cardiac line), I had to jump on top of him and do compressions. I had to do compressions all the way to CCU (cardiac care unit). I had to ride the stretcher cause I was the smallest one. But I maintained my comfort, I maintained my, you know, my demeanor, the whole time, until afterwards, I said, 'Oh my God, I can't believe I did that!!'"

Jeannie: "So basically, during the situation you're able to think clearly, and then afterward, it's like 'Oh my God!'"

James: "Yes. Yes. Most definitely."

Jeannie: "How do you feel when it's over? Do you feel relieved, do you feel good? Do you feel like I don't ever want this to happen again?"

James: "Most definitely. It's like, God, I hope this doesn't happen again. But at least I did what I needed to do. I have a sense of, you know, comfort, that I was able to be accessible. That I was able to do what I needed to do."

Jeannie: "That you were able to function in that situation..."

James: "That's right."

Jeannie: "So that was a good feeling."

James: "Oh, yes, most definitely."

Jeannie: "Ok, let me ask you this. You mentioned a minute ago—oh, two things. First of all, have you had a patient die on you?"

James: "Oh yes."

Jeannie: "How did you feel? Did you worry about that?"

James: "I was very, very worried. I was very emotional. I mean, I didn't go out and hoot and holler and cry. But I feel like—I'm a very emphatic person, and for me being in a situation where I've lost my family members. After the situation, I just sit there and I'll embrace the family. I'll hug them, I'll tell them I'm so sorry, I did all I could. And they'll tell me thank you so much. And with me being emotional, a tear might run down my eye. You know, things like that. But when I go back to the station—oh, the grim reaper did it again. So, you know, I'm not supported by my staff. So it's kind of like I'll isolate myself from the staff. I sit down the hall. I only ask what I need. I only fool with who I need to fool with. And I'll put more of my energy into my patients. My patients know more about me than my co-workers. I really have alienated myself from my co-workers."

Michelle had not had the experience, but it was always on her mind.

Jeannie: "Well, do you have concerns, or do you worry about patients, when you say they're going bad, do you worry about that?"

Michelle: "Yes, I mean I know I'll know what they have going bad, but I don't know if I'll know about the early signs, or recognize, not that I won't know..."

Jeannie: "Have you had that happen yet?"

Michelle: "No!"

Jeannie: "Have you had a patient die?"

Michelle: "No!"

Jeannie: "Have you run a code?"

Michelle: "I've gone in there, but I didn't have to do anything."

Jeannie: "How did you feel when the code was being run?"

Michelle: "Oh, that was nerve-wracking. But, nobody lived. I guess that's just—I guess you just get used to it because they just say, hey we're going to a code, and I'm just freaking out!"

Jeannie: "Freaking out in what way?"

Michelle: "I guess just the fact that I felt like I was in slow motion, and I wasn't doing anything to help. And..."

Jeannie: "What were you doing?"

Michelle: "I just had to stand there. Draw up saline flushes, that was it. I guess because I haven't had ACLS yet."

Jeannie: "ACLS is..."

Michelle: "It's I guess the class that teaches you how to be prepared for it. So I'm taking that in October."

Jeannie: "So you think you'll be more comfortable after you take it?"

Michelle: "I hope so. The other nurses say that once you're in there you're kind of, you know, they know what to do, but they're not thinking about—they're just listening to what the doctors have to say."

Jeannie: "They're kind of on an auto pilot, doing what they have to do? Is that what you mean?"

Michelle: "Yes ma'am."

Jeannie: "So the patient—are you worried about a patient dying on you?"

Michelle: "I mean, yes, yes!"

Jeannie: "How then, do you think about that when you go to work?"

Michelle: "No. No."

Jeannie: "You just know it's going to happen....eventually (we both laugh)."

Michelle: "I guess so..."

- **What has helped with transition?**

Of interest was the significance of working the night shift. Although not all RNs worked nights, they expressed how working nights could be of value. The reason that some of the RNs worked nights was monetary in nature due to the shift differential, while others were motivated by other factors. Fewer managers, administrators, and physicians on the unit were expressed, as was the idea that the night shift was a slower pace. However the nurse-patient ratio tends to be higher. Mary discussed why she changed to the night shift.

Jeannie: "Um, what about working nights?"

Mary: "Nights? I switched to nights for the simple fact that it's got to be a little slower because you don't have all of the surgery admits. Because that's what kills me."

Jeannie: "Let me clarify this; you were not originally hired for nights?"

Mary: "No, I was hired for days."

Jeannie: "But you asked to go to nights (she nods yes). OK, I guess I just misunderstood. I was thinking that you oriented to days, and then you automatically switched to nights."

Mary: "I worked days for a few months, like two months maybe. And really the discharges and admits just killed me. As soon as you get caught up, you'd have two empty rooms, and you know they're going to be filled up in the next hour. And just knowing that you were always constantly turning patients over. It's a real big stressor. So I switched to nights thinking that it's got to be a little bit, a little bit better, because you don't have all of the surgery admits. You do have ER admits, but you don't have surgery admits. Well, you still have surgery admits, they just come at the very beginning of your shift. And I do feel like there is more time to catch up if you get behind as long as nothing drastic happens in the middle of the night. Um, I think it's really good experience as far as a new graduate because you get to know the charts so much better. Some of the things you look at the chart, you're like, I don't know where to find this, I don't even know how to read this. And I see now I've gotten better, and I know what I'm looking for. Doing the chart checks, and also seeing the big picture of things. Not just the patient needs this medicine, and this

medicine, and a dressing change. It's more like, so this is what the doctor said about this in the progress notes. That's why they want to do this."

Jeannie: "Or that they're looking for this... I see that now...it's more than just a procedure."

Mary: "Right."

Jeannie: "Do you want to stay on nights?"

Mary: "Um, I'm going to stay on nights a little, probably a few more months, to hopefully try to get a little bit faster. Better with my time management, and a little bit faster. Also with the hospital community itself. There's still things you don't know about the unit and not very quick with the computer system. All of that takes time, and you don't realize that when you start, but all of that takes time. So, I think I need to stay to get more familiar with things. But nights, I have no problem staying up at night working, but it's the flip flopping back and forth when I'm off."

Jeannie: "Your body clock?"

Mary: "Yes."

Michael works weekend nights, which he intentionally chose due to the staff.

Jeannie: "So, you've got a patient that you go in and check and they're not doing well. And you know that you need to run a code. Do you have good support?"

Michael: "Definitely. Well, that's the reason --it was mainly because of the decision I chose at the time to be on that shift, because we have really good nurses on that particular shift. Some other shifts weren't nearly as experienced, no not at all. They actually left me a one-year graduate in charge. That happens a lot unfortunately. That happened to me. Six months out of school I had to charge."

Anna works nights because of the salary and the hope that the pace is somewhat slower. She also talked about the difference in working the weekend nights.

Anna: "Five [patients] is good. But it's like, I don't know. If I had four, and you gave me an admit, I could probably handle that with no problem. I could have six, and you get an admit in the middle of the night---they

admit pretty good. You'd think nights wouldn't be quite so bad. I don't know what the day is like, but..."

Jeannie: "Do you like working nights?"

Anna: "Um hmm, it's ok. "

Jeannie: "Is that what you wanted to work?"

Anna: "Yes, for the pay. "

Jeannie: "The pay is more?"

Anna: "Yes. I figured it would be a little bit more relaxed, but ..."

Jeannie: "That was one of the reasons you selected it?"

Anna: "That was one of the reasons. You know, especially just starting. I figured nights would be calmer. I could learn things."

Jeannie: "Have you worked any days at all?"

Anna: "No. At [names another hospital] I did."

Jeannie: "Ok."

Anna: "The days there are a lot slower than they are here."

Jeannie: "Oh, really?"

Anna: "Yes. It's just easier. They send out all of the real bad people."

Jeannie: "To you." [referring her present place of employment]

Anna: "Yes. They don't have the equipment to take care of them."

Jeannie: "From the perspective of nights, do you think you want to stay on nights?"

Anna: "Yes."

Jeannie: "So this has been a good place for you to be?"

Anna: "Yes, on nights. The weekends seem like they're a little bit better."

Jeannie: "Why? What do you think is different? People still get sick on the weekend."

Anna: "People still get sick on the weekend, but there just doesn't seem like there is as many admissions on the weekend. I don't know I haven't worked them a lot. But, the doctors don't come around as much. There's not as many people."

Jeannie: "The staff--wait—the doctors don't come around as much?"

Anna: "Yes, and not as many orders..."

Jeannie: "Not as much stuff going on?"

Anna: "Right."

Jane works the day shift, but recognized the value of a new graduate RN working nights.

Jeannie: "You work days?"

Jane: "Yes."

Jeannie: "Have you ever worked nights?"

Jane: "No."

Jeannie: "Do you think you should?"

Jane: "Um, as far as like working all the time nights?"

Jeannie: "No. just as far as"

Jane: "Oh, yes. I think that included in your preceptorship, you should have a couple of shifts to where you work nights. Just like three nights, you know, on a regular shift week, that you would normally work three or four days. You could do one of those weeks working three days of nights and that would kind of give you a continuum of care as well—because you're dealing with these patients while they're sleeping, while doctors aren't readily available, pharmacy is not 24 hours at our hospital, so, you know, any medications that have to be reconstituted, or things like that, the night shift has to do that. So it's a totally different playing field, but do I feel like day shift has it any easier than night shift- no. I feel like you're a 24-7 business, and there's always going to be something going on. It's just how you handle things differently. Um, I think that when you do 12-hour chart checks versus 24-hour chart checks, and you're not just checking you charts—you're checking your MARS, and you're checking—you

know—I think it's going over it more with a fine tooth comb than what day shift pretty much does. A 24-hour (chart check) it a lot different than a 12-hour chart check. I've never done a 24-hour chart check. And as far as getting your MARS up, you know, I feel like when I get report in the morning, they have more time to go look at the history, the patient's history, the patient's labs, throughout the whole day. Not just the morning labs that you get, or the criticals that get call. Things like that. They have more down time, because patients are sleeping for a little bit longer than they are during the day. There aren't the number of procedures going on during the night, there's just more time to look at a chart, and to let you know what's up and coming the next day. I feel like it would have been helpful to get that experience so that I could also be a little more sensitive to what the night shift has going on during the night to see if there's anything I can do during the day to help them. I kind of learned that the hard way, because, you know, I have had people come to me and say, 'You didn't do this,' or 'you didn't do that. Just be more careful of checking this on your charting;' things like that...as far as not the flowsheet, but the chart in general. So from that standpoint I think that night shift would have been beneficial. And they are doing that now, and I told my manager that I wasn't opposed to doing that a week of night shifts at this point in my career, but I didn't want to be left on my own. I still wanted it to be a preceptorship. Because I didn't want to be responsible [without backup] because I've never worked nights."

Robert works the night shift. He shared his experiences relating to working nights.

Robert: "... I don't ever see him because I'm on nights [his manager]. That's one thing, I'm working nights, so..."

Jeannie: "Ok. Tell me about working nights. Why did you decide to work on nights?"

Robert: "That's the only thing he had open, but also it's more money and you don't have to see all the management."

Jeannie: "Is that good for you?"

Robert: "Oh yeah, I'd rather not see them, because you don't what they'll come in and tell you (laughs)."

Jeannie: "So you're on at night and you're the nurse. Tell me about that kind of experience."

Robert: "Well, you take more patients."

Jeannie: "Ok. Tell me about that."

Robert: "Well, most of the time I have seven patients, and that's the most you can get."

Jeannie: "How do you feel about your patient load?"

Robert: "Depending on how sick they are, it's some days it's ..."

Jeannie: "They're sick."

Robert: "Oh, well, I'd be lucky if I get to open charts by midnight. But um, they just, I don't know why they think they need less at night. I guess because everybody supposed to be sleeping but I've noticed no patients sleep in the hospital. They're constantly up and up and down the hall and walking in rooms."

Jeannie: "There's a lot going on in the hospital, huh?"

Robert: "Yes."

Jeannie: "Do you like working nights? Do you think it's a good place for a new graduate to work? A good time frame, I'm sorry."

Robert: "Well, the girl that they hired, she's on days. I know they have a lot of discharges and all that mess like that, but um you have to deal with a lot. We rarely have to deal with discharges and sometimes things carry over if the doctor comes in late."

The importance of an excellent preceptor was of great value to the new graduate RNs. The preceptor served as a teacher, role model, and support system. In addition, a supportive manager was important. Michelle had a very good experience with her preceptor. She shared her thoughts about working with her preceptor and manager.

Jeannie: "... What do you consider to be the most important factors that would contribute, or did contribute to your success as a new RN?"

Michelle: "Like when I was in school? Or out?"

Jeannie: "Either way."

Michelle: "I guess the teachers when I was in school. No matter what, they were always there to help. With me being out, I guess the preceptor helped the most."

Jeannie: "Ok. And the preceptor is..."

Michelle: [gives name]

Jeannie: "What is the role?"

Michelle: "I guess just making sure I knew where everything was in the hospital. Where they put stuff, how to chart."

Jeannie: "And she's still there for you?"

Michelle: "Oh yes!"

Jeannie: "Um, what else has made it easier for you with the transition?"

Michelle: "I think the hospital atmosphere is not that—it's kind of relaxed—well not relaxed, but no one's really uptight. Our boss is real easy going."

Jeannie: "So what about your boss? Has your boss been support to you?"

Michelle: "Um hmm. He's good. If I have any questions, I feel comfortable asking him."

Jeannie: "You're comfortable going to him..."

Michelle: "Yes."

Michael's experience working with his preceptor was also a positive one.

Jeannie: "So you're in orientation now. What kind of experience was it for you?"

Michael: "Uh, actually had a very good—I lucked out because our unit was in transition, and we didn't have a lot of experienced RNs to orient people, on days especially."

Jeannie: "Ok..."

Michael: "So the shift that I work has a very experienced RN and that's the reason why I chose it, so I could have some good experience passed

on to me, so I chose an overnight position really mainly because of the experience that worked there at night at the time.”

Jeannie: “So your preceptor then was an experienced RN?”

Michael: “Very much so.”

Jeannie: “OK.”

Michael: “Over five years experience.”

Jeannie: “What did she do that was good to help you?”

Michael: “Just um, you know common sense knowledge. I mean clinical knowledge that you learn in school, but really more than anything she helped me learn things in the hospital. The organization, that sort of thing. A lot of the things you learn in school, but you know, it’s how things work there.”

Jeannie: “Unique to that facility?”

Michael: “Exactly. Because you come with the nursing knowledge. That’s there. But the hard thing to learn, the nursing curve, is learning who to call for this, what to do for that as far as the facility-type workings.”

Anna experienced a change in preceptors because her original preceptor was a travel nurse who left. Anna was having a good experience with her preceptor, and describes what happened when there was a change.

Anna: “Well at first I was kind of excited about it [her new job], and I had it all worked out, I had been there before [in school], and I was orienting with my preceptor, she was fine, and everything. I felt really comfortable until she left her job because she’s a travel nurse. And she left and went to California to work. So I was really uncomfortable just being...this is not completed sentences at all...”

Jeannie: “It’s going to be transcribed, but don’t worry about it. We’re not looking for the grammar or anything, we’re looking at your experience. Ok, tell me about your preceptor experience. How long were you in orientation?”

Anna: “Six weeks.”

Jeannie: “Is that long enough?”

Anna: "For me, probably not. Because I never, like...I only had seven patients for two weeks. So I guess that was a real problem. But I never said anything about it."

Jeannie: "Why not?"

Anna: "Really, I didn't think that being with my preceptor for a couple of more weeks really was going to do that much good. And another thing, whenever my schedule came out—when my first preceptor left, she put me with another girl that worked there."

Jeannie: "Did you precept on nights or days?"

Anna: "On nights. I worked with my preceptor for a couple of weeks, and then I wasn't on her schedule any more. I thought it would have been helpful if at least I was on her same schedule, not working with her side-by-side, but at least put me on her schedule because I know her, and I'm comfortable asking her questions and stuff. It would have been better if I would have known that she was there."

Jeannie: "Why do you think that was?"

Anna: "Why they didn't put me with her? I don't know. For two days she was with me, but other than that..."

Jeannie: "So let me clarify. When you were the new orientee, how many weeks did you have on the floor with your preceptor?"

Anna: "Six weeks."

Jeannie: "Six weeks on the floor. Did you do other things?"

Anna: "I was never put with the unit clerk. For four hours I was supposed to be, but I didn't. There are two unit clerks that work there [gives names]. My first preceptor never wanted to put me with Ms. [gives name] because she's not nice, and she's real snappy. And I didn't want to be put with her anyway. Like I figured I would just learn it myself as I went along, rather than sitting with her side-by-side. And the other one, Ms. Thomas, it just never worked out that I could be with her, so...I never got that experience. But that really hasn't been that big of a problem, because you have to learn the computer fairly easily, so that wasn't one of my big concerns."

Jeannie: "Well, so, as you look back, seven weeks was or was not enough...six weeks."

Anna: "I mean, I probably could have gone a little longer with my preceptor having seven patients. But I didn't."

Mary also had two different preceptors, but had a better experience.

Jeannie: "Your preceptor—let's talk about your preceptor. Was that a good experience for you?"

Mary: "Yes."

Jeannie: "Was that a consistent person that was there with you all the way, or did you have different people?"

Mary: "I had two different people mainly, then when of course I went to nights for a few nights, that was a different person. Um, it was basically two main people. One was a veteran nurse of about ten years. The other one had, she had only been there...I think she was a graduate of the [names school] program and she had only been out for like ten months—not even quite a year. But, she was actually very good too. I don't think it was bad that I had two preceptors, because you pick up different things from different people. And you can kind of see—get different ideas how to work."

Jeannie: "Different things from different people."

Mary: "Exactly."

Jeannie: "How did you know that it was time to go on your own? Was it decided for you, or..."

Mary: "It was pretty much decided. Basically, the schedule came out and I was on my own, and I was like oohh, wait a minute, I'm not ready for this yet. And they were able to fit me in about another week and a half of orientation. So I did do that, and I was able to pick up a couple of extra shifts just because I wanted some extra time, and I did that."

Jeannie: "Do you feel like, in general, looking back, you've been out on your own now a couple of months, do you think that the orientation period was long enough?"

Mary: "I think, I think it was long enough...of course, you're never ready when it's time. I don't think you can ever be ready?"

Jeannie: "What makes you feel you're ready? What key points make you feel you're ready?"

Mary: "You know, I don't know. I just remember going out that day I was on my own and you just get it done. I just got it done somehow."

Jeannie: "You do what you have to do?"

Mary: "Exactly. You do what you have to do and you get it done. You ask a lot of questions, and you just get it done."

Jeannie: "What about asking those questions, Mary? Do you have any problem getting help from people or a response from people? From co-workers?"

Mary: "No, no. everybody over there is pretty much really helpful. They have good veteran nurses who have been there for years, and then graduates who have been there since December, so.."

Jeannie: "People at different points in their lives and careers?"

Mary: "Yes, yes exactly. And then, so, it's really a good mix, and really everybody is really helpful. I do feel like just because I do ask all of those questions that I'm kind of a burden."

Jeannie: "Really? Is that your own perception, or do you get that..."

Mary: "Yes, that's my own perception. I feel like just because, and it's little things I think I should know and some times I just want to run it by somebody to make sure before I go do something."

Mary later expounded more about her orientation period and what could have helped her become acclimated to her new role.

Jeannie: "What could have been done differently or more effectively, if anything, that would have assisted you in becoming acclimated to your new role?"

Mary: "The orientation period. Like I was saying earlier, we oriented to the charge nurse position, the unit clerk position, the night shift, and we also did the EKG certification and the ACLS certification in that orientation period. So all those hours spent doing that, I feel that it would have been better for me to spend it with the preceptor. And then get ACLS certified later..."

James did not have a good experience with his preceptor. He described a language barrier that hindered his learning.

Jeannie: "Is there anything else you can think of that you could add, because this is all about your experience as a new RN, is there anything else that you could tell me that was positive? Did anything help you? Did anyone help you—did you have a preceptor?"

James: "Yes."

Jeannie: "Did your preceptor help you transition?"

James: "No she didn't. My preceptor was Philippine, so we had a very big language barrier. We also had a cultural difference. She felt that I was arrogant because she said it looks like I hold my head up. I'm short!!"

Jeannie: [Laughs] "I am too!"

James: "I mean, I'm kind of like that all the time. I look up at everybody so you know, I can't help it. And you know, she said I have an air, and like I think I know too much. I asked my manager if I could have another one, and she said no, she's the best one up here for you."

Jeannie: "How long did you work with her?"

James: "I worked with her from January to March."

Jeannie: "That's right, you told me that. I apologize."

James: "No problem!!"

Jeannie: "So, was that on days or evenings?"

James: "That was on days. At that time, I was working 7a to 7p. At the time, three days a week."

Jeannie: "Is there anything that could have helped you transition easier into that role?"

James: "I think if I had a preceptor without a language barrier would have been better. Someone that, you know, I just think that her being Philippine, and myself being American, I think that was the biggest thing there. And I'm not being ethnocentric, or whatever that is. I just --I feel like that was the biggest problem. I mean, any other nurse I could have--She taught me a lot skill-wise. The LPN's have helped me out a lot, you know the older LPN's. they taught me a lot of skills. Because, like I said, I have knowledge, I didn't have the skills. And I didn't work as a tech coming up, I just went straight through nursing school to work. So they helped me out a

lot. I can say that much. The LPN's, some of them, one or two of them, have helped me out a lot."

- **What does it mean to be a new RN working in an acute care hospital setting?**

Despite the fact that the new RNs were overwhelmed and anxious, it was apparent that they were very proud of their accomplishments. They recognized the responsibility of their role, but were proud to call themselves "RN." Mary explained how she felt when she initially realized that her role was indeed real.

Jeannie: "After you started your job and you got into it, did your feelings about your new role change at all?"

Mary: (quiet and thinking...)

Jeannie: "I guess what I'm saying is, were the ideas that you went into it with—I'm a new nurse now, I'm a graduate, I'm a nurse, here I am...."

Mary: "You know, I think it was hard for me to even say that I'm a nurse."

Jeannie: "Really? Tell me more..."

Mary: "Because for so long, I'm a student from, you know, [states school], and I'm going to be working with you and nurse so and so today. Even with a preceptor, 'My name's Mary, ' um, and well, in orientation, I really wasn't a nurse because I hadn't taken Boards yet, so I would say, 'My name's Mary, and I'll be taking care of you today with so and so...' so there was always, you know a net, thinking that there is, so it was almost like when you would go into the patient's room and say 'My name's Mary, and I'm going to be your nurse today'.... And I am!!"

Jeannie: "What does it mean when you say that—I'm a nurse."

Mary: "Accomplishment. A big accomplishment that I finished something and I'm responsible for these six people."

Jeannie: "Their lives are in your hands."

Mary: "Um hmm..."

Jeannie: "So how do you feel when I say that? Does that make you feel overwhelmed, or is it like—it's pretty good, I'm good with it?"

Mary: "Um... no I'm pretty good with it. Maybe in the beginning it was a little overwhelming, and maybe that's why it was hard to say I'm going to be your nurse tonight or today. But yes, I think I'm more comfortable with it now."

Jeannie: "Good. As time goes on, it gets easier?"

Mary: "Pretty much. You always have those nights or days, you know, when you kind of question..."

Jeannie: "Question in what way?"

Mary: "Just when, you know, ten things seem to happen at once, and you know, someone's on the phone for you, a doctor wants you in this room, someone calls for pain medicine, somebody needs this, an IV is beeping, you know, things like that, you know, can get a little overwhelming, and you question can I handle all of this."

Although Robert recognized the responsibility of being an RN, he had to get comfortable asking for help from others. He explained his experience.

Jeannie: "Well, in an acute care setting, in the kind of unit that you work on, what does it mean to you to be a registered nurse on that unit?"

Robert: (quiet) "I don't know, it feels odd sometimes that you have some kind of weird power that you never had before."

Jeannie: "Really?"

Robert: "I don't know, it's not like you have power over somebody but you're the one making the decisions."

Jeannie: "How do you feel about that?"

Robert: (sighs) "If I know what's going on, I feel all right, but if it's something new..."

Jeannie: "What if you don't know what's going on?"

Robert: "I go ask the charge nurse."

Jeannie: "How do you feel asking the charge nurse?"

Robert: "Well, I'd rather do that then let something happen to the person."

Jeannie: "Do you like going and asking questions?"

Robert: "No, but I had to get over that because I don't know everything. So I'd rather them say, 'hey, this is what we usually do' or this is what we could do, but... I don't know...then I make the decision from there.'

Jeannie: "OK, and you've learned from that every time something happens?"

Robert: "Yes."

Michelle found it difficult to believe that others would ask her professional questions or advice about patient care.

Jeannie: "Ok, now. Think about this. You've been out for a few months. So what does it mean to you now to be a registered nurse in an acute care hospital setting? What does it mean to you inside and"

Michelle: "I mean I guess I feel good that I'm capable of something...ummm I don't know..."

Jeannie: "Sure you do. Think about it. Are you...I mean I don't want to put words in your head."

Michelle: "Right."

Jeannie: "But you're the registered nurse on the floor—so think about that. What does that mean from the perspective of you being the registered nurse on the floor?"

Michelle: "Well, I have people who will talk to me and ask questions."

Jeannie: "Ok, ok."

Michelle: "I've noticed that the LPN who has been there forever but she asks me questions."

Jeannie: "How do you feel when she asks you those questions?"

Michelle: "I guess good, but it's kind of like she should ask somebody else. I mean I don't know any more than she does. She's been there for like 20 years. But it feels good that she feels confident in me to ask me questions."

Jeannie: "Has anybody else done that to you—come to you for assistance?"

Michelle: "No. Maybe the students, but that's all."

Jeannie: "Student nurses from different facilities and schools?"

Michelle: "Yes."

Michael is proud of his accomplishments. However, he was somewhat surprised about how mentally and physically challenging his job can be on any given night.

Jeannie: "Well, then. Let me ask you this. As a new RN, or as an RN now, you're a Registered Nurse. What does that mean to you to say that now?"

Michael: "Uh, it's definitely an honor to be in charge of their care while they're in the hospital. Managing their care and to be there to take care of them. An asset to them, definitely. It really means something."

Jeannie: "When I ask you what you do for a living, and you say I'm an RN, what does that mean?"

Michael: "I, to me, I'm definitely proud to be an RN. And I feel that it's a tough job. It's not easy. Many times. And I feel that that's something to be proud of."

Jeannie: "Did you anticipate it to be as tough as what you've found?"

Michael: "No. Well, no. Sometimes it is physically demanding. Many times. And you're like on the third night, you're just like, man, I'm worn out! And so, yes, I didn't anticipate that part, especially. And a lot of times they cut your help back, so you're doing most of the things by yourself. Or you have to get another nurse to come in who's just as busy as you to help you. But anyway, I didn't anticipate it to be to be as physically demanding as it has been sometimes."

Jeannie: "What about mentally?"

Michael: "Mentally, it's been—when I was new, it was much more mentally challenging. And it's learning the curve, the learning curve. Trying

to figure out the facility, you know, where things are, how things happen, what number to call. All those sorts of things, really, that you don't learn in school."

Jeannie: "OK, it's four o'clock Saturday evening, and it's time to go to work. Get ready. How do you feel?"

Michael: "I used to dread it bad. And really, just the whole way up there. Now it's not so bad. It's really not. I pray anyway, but as far as the dreading, I hope everything's going to go well. Have a good weekend. But I don't dread it as much as I did."

Jeannie: "Really?"

Michael: "Yes."

Jeannie: "Do you know when that changed?"

Michael: "I think it definitely changed after the year mark. Uh, yes. I want to say the year mark. Right after the first of the year. A lot of it has to do with who you're working with, it really does. And who you're working behind. That makes or breaks you."

Jeannie: "It makes it harder?"

Michael: "It really does. It really does. Whether or not you have a good nurse, or whether they didn't give a crap. And you're having to do all the things they should have done anyway. Or you've got to call the doctor about things they should have called the doctor about. And you're getting chewed out for something that should have been handled. Those kinds of things that are unique to shift work, really."

Jeannie: "What do you like most about being an RN?"

Michael: "In this particular setting? I like being able to do good. I like being able to be a positive influence and experience on somebody's life. So that's very rewarding."

- **Intent to Stay or Leave the Acute Care Unit**

Of interest were the overall feelings about whether or not each participant was planning to stay on the acute care unit. Many of the RNs were using this type of unit as a stepping stone to a specialty unit, and very few intended to stay

for any length of time. They recognized that the experience gained in this type of setting was invaluable, but did not desire to stay. Some were even surprised that they had made the decision to stay on the unit.

Jeannie: "Where do you see yourself in a year, from a nursing perspective?"

Michelle: "Maybe still work on med/surg at [names hospital]."

Jeannie: "If you had an ideal place to work, where would it be?"

Michelle: "I think I want to go to [names hospital] and work in labor and delivery. That was my favorite in school."

Jeannie: "When do you think you'll be ready to do that?"

Michelle: "I guess when I'm comfortable enough in this pace that I'm keeping up, and a better job in the med surg floor."

Jeannie: "Ok. So you feel like you'll know."

Michelle: "Yes. Or ICU."

Jeannie: "Really? What would be different with the one-on-one care?"

Michelle: "I guess I just feel like I'd be giving them better care. I know they're sicker people, but I feel like I'd know what was going on with them."

Jeannie: "Do you worry that you're not giving good care to your patients? And the reason I'm asking you that is because you've mentioned that a few times."

Michelle: "I mean, not that I'm not giving good care, I just think it could be better."

Jeannie: "What would you do different?"

Michelle: "I guess just at least talking to them. I talk to them in while I'm in their room, but just answer their questions. I don't even have time to read back through their charts."

Mary was surprised that she now feels that she might stay past the one year

mark. She also explained what could have been done more effectively to help with her transition.

Jeannie: "Do you plan to stay on that kind of unit?"

Mary: "For, originally I had planned to stay at least a year, because I wanted at least a year of good med surg, and probably thinking of moving to ER after that. But, you know, it is a good unit, and I like the people I work with, and I do like what I'm doing, which surprised me. Even though there's a lot going on, and a lot of work to be done, I do like what I'm doing, so I think I may stay there longer."

Jeannie: "That's great. If your unit manager, [gives name] came to you, and said if you stay here with me, I'll give you the schedule you want, would you stay here?"

Mary: "Yes, I like the work I'm doing, I like the patient care. I like being responsible."

Jeannie: "You like being a nurse?"

Mary: "Yes. I do."

Robert states that he would remain working on an acute care unit only if his student loans are paid off.

Jeannie: "What would keep you on the floor?"

Robert: "If they would pay off all of my loans."

Jeannie: "That would be the only thing that would keep you there?"

Robert: "Um, right now, yes. Until the loans are gone, I can't think of anything but getting rid of them."

Jeannie: "OK, but let me clarify this. What you're saying is if they offered, if they said, 'Robert, today if you stayed on our floor for the next three years we'll pay off all your loans,' you'd do it."

Robert: "Yes." [answers matter-of factly].

Jeannie: "If they said, 'Robert, we're not going to do this,' you're out of there."

Robert: "Bye bye."

Jeannie: "And It doesn't matter if you stay in the hospital or go somewhere else."

Robert: "Yes. I wouldn't mind moving out of state."

Jeannie: "Oh really?"

Robert: "That's one thing too. I hear about, well right now, after that year, what I was thinking about doing is maybe doing that travel thing once or twice."

Jeannie: "Travel thing?"

Robert: "Travel nursing. Where, I hear all these people coming back saying its \$50 an hour for the first eight hours and \$75 for the next."

Jeannie: "So, salary is a driving force for you?"

Robert: "Well right now, yes. I don't know, I couldn't understand it, because when I was in school I lived off student loans. And that was, what? Three thousand for four months- five months. And I lived off of it until the next loan. And I worked every other weekend, which was only maybe a \$100 a week. And I managed to do all kinds of things. I had money to go play with and all kinds of stuff. But then, now I'm getting paid more than what the loans were giving me and I don't have any more bills, nothing, and it's all going away. I don't know where all of it goes. [We laugh together] I'm ready for some play money."

Jeannie: "Ok, so money talks."

Robert: "Yes. Well, not always."

Jeannie: "What else besides money?"

Robert: "Well there's the group working environment."

Jeannie: "Define the group working environment."

Robert: "Um, everybody doesn't have to get along, but at least be civil. Uh, It's [the unit] is organized, things are in place where they're supposed to be, and um..."

Anna was very emotional throughout the interview, and often cried as she

discussed her experiences. She stated that she is very unhappy, and does not intend to stay.

Jeannie: "Do you think you're going to stay?"

Anna: "Probably not. I really do not like it. Not one bit. [starts crying again]. Really, it really causes problems between me and my husband. Truthfully."

Jeannie: "Because....you're unhappy?"

Anna: "I'm unhappy. He wants a family. I have insurance. I mean, I'm not going to have a baby if I have to stay here. Because basically what it boils down to is...." (problem with tape here. It cut off for a second.)

Jeannie: "Do you think that, you realize that it might get or it's going to get better in time? Is that what you're waiting on?"

Anna: "Well, I'm waiting to get at least six months in, is what I'm waiting on."

Jeannie: "And then..."

Anna: "And then I don't know what I'm going to do from there. I mean, it may get better, but it just doesn't seem like it."

Jeannie: "Um, but it might happen?"

Anna: "Every time you go to work, it's just something new. I don't know. The girl that's been there for a year and a half. You would think that she would be able to just take it, like it wouldn't affect her as much as it does me. You know, she's still running around, stressed out. I mean, it's to the point of tears last time, because she has, I don't know, a fresh out-patient and all kinds of stuff going wrong with him."

Jeannie: "So, does it seem like, from your perspective, that you don't have enough support on the floor at nights?"

Anna: "I don't know if that's the problem or not. I don't know."

Jeannie: "It's way too much?"

Anna: "It's way too much. I mean, especially just coming out of school, it is a lot. I don't know."

Jeannie: "It's just way too much."

Anna: "It's too much."

Jeannie: "And if you had a smaller number of patients, you thought you could manage it?"

Anna: "It would be a little better. Yes. I mean, if they could have one more nurse to the floor, really, what is that going to hurt? The patients would be taken care of...."

Jeannie: "You're frustrated because the patients aren't –you don't feel they get the best care you can give?"

Anna: "They're not. No."

The supportive co-workers that Michael works with are an impetus for him to stay on the unit. His original plan was to go to a specialty unit, but Michael has since changed his mind.

Michael: "Really, I like the job, and I like what I do. I think what makes the job a lot worse than it should be is the way the hospital is working. Whether or not they're asking too much of you, like cutting back. We have some people, even though they know you're going to need—you're going to be admitted to, or those types of things make it a lot worse than it should be. Just the daily operations of the hospital, like many times with staffing, and that sort of thing they really switch."

Jeannie: "If you look down the road in six months, where do you think you'll be?"

Michael: "Six months I'll probably still be there. I'm going to be going back to school."

Jeannie: "Are you?"

Michael: "Um hmm."

Jeannie: "What do you want to do?"

Michael: "I want to be a NP (nurse practitioner). I'm more interested in primary care, and I also there for a while when I was going through the rough times, wanted to work in Home Health. But that's kind of came and went, but ..."

Jeannie: "What about home health?"

Michael: "Yeah, but I started to look into it, but decided not to."

Jeannie: "What made you decide to change your mind?"

Michael: "With the home health? It was driving and stuff. I mean, I liked some of the hours, and that sort of thing, but I really didn't want to do that."

Jeannie: "Do you think that, you mentioned earlier, when we first started talking, that ultimately working in ICU. Is that still a goal of yours?"

Michael: "No. I've decided... I now know that I don't like the really—I don't like the really, really acute ones—that could die at anytime. I'd rather not deal with that. And I thought I'd want to do that before. But when you have two patients that's going on, it's a lot better than six. But I really, I prefer, I think I'd prefer the primary type setting."

Both Jane and James are planning to leave the acute care hospital setting.

James already has a new job at another hospital.

Jeannie: "So do you feel that if there's a concern, you're afraid to address it?"

Jane: "Oh, yes, I'm afraid to voice my opinion about anything."

Jeannie: "What would they do? What will you do?"

Jane: "Probably leave the unit."

Jeannie: "At what point?"

Jane: "Um, probably after I get one year."

Jeannie: "When you say leave the unit, did you mean that unit, or go another acute care unit, or do you want a specialty area?"

Jane: "I want more of a specialty area. I want more critical care. I hate saying just a blanket expression that I'm bored with the unit, because bored to me seems like you're not busy enough. But, God knows, I am sometimes running with my head cut-off, you know, like a chicken. But I don't, I just want to be more involved with the patient at the bedside."

James's frustrations and sense of loss were apparent as we concluded his

interview. However, he was not going to be beaten down! James talked about his impending job change with a sense of hope.

James: "That's why I chose home health. I'm going to be out in the field, not around anybody, that's why I think it's what I need to do to see how it is."

Jeannie: "When do you start?"

James: "Well, pending the drug test, which I know I'm going to pass...it should be within the next two weeks."

Jeannie: "Is there anything else you'd like to add? Did I kind of cover your experiences?"

James: "You did, and you've also helped me to vent a lot. "

Jeannie: (I laughed).

James: "I have been holding this for I don't know how long."

Jeannie: "Well, nobody will hear this [tape] except me and my major professor."

James: "Oh no, no, no, I am not worried about that."

Jeannie: "I sense your frustration."

James: "Yes, and I wish you could feel my heart— I mean I have a heartache just talking about it."

Jeannie: "I can tell."

James: "I'm almost to the point of tears."

Jeannie: "I know." [he really is]

James: "Because I am very, I'm very disappointed, I'm very disappointed. But, I'm not going to stop."

Jeannie: "It's not going to stop you!"

James: "No. I'm not going to stop."

Jeannie: "You still know you have a lot to offer your patients."

James: "I know I'm a good nurse, because I have been through the fire myself. I've taken care of my family, and I treat my patients with kid gloves. I'm not going to let those ladies on that unit defeat me. I'm not going to let that hurt me."

Jeannie: "I'm very sorry that's happened to you."

James: "I'm more sorry than you, because coming from a hospital that I had the utmost respect for, that I, the people I've worked with over the years, that I've had utmost respect for, I've lost it. And that's the worst thing you can do is lose respect for someone."

Summary

This chapter presented the horizons, invariant horizons, and the textural and structural descriptions of the data. In addition, my own textural descriptions and reflections as the researcher were described. The themes that evolved were common among all of the participants. All participants were excited but nervous about beginning their new role as an RN in an acute care hospital setting. They were all committed to patient care, and wanted to be able to serve as a patient advocate. In addition, the new RNs were very frustrated by high nurse-patient ratios and short orientation periods. They identified many stressors, such as interacting with physicians and concerns about a patient's condition deteriorating. Ultimately, many of the RNs planned to leave their position in an acute care hospital setting. However, those that chose to stay were somewhat surprised at their decision. Figure 8 summarizes the experiences of all new graduate RNs working in an acute care hospital setting.

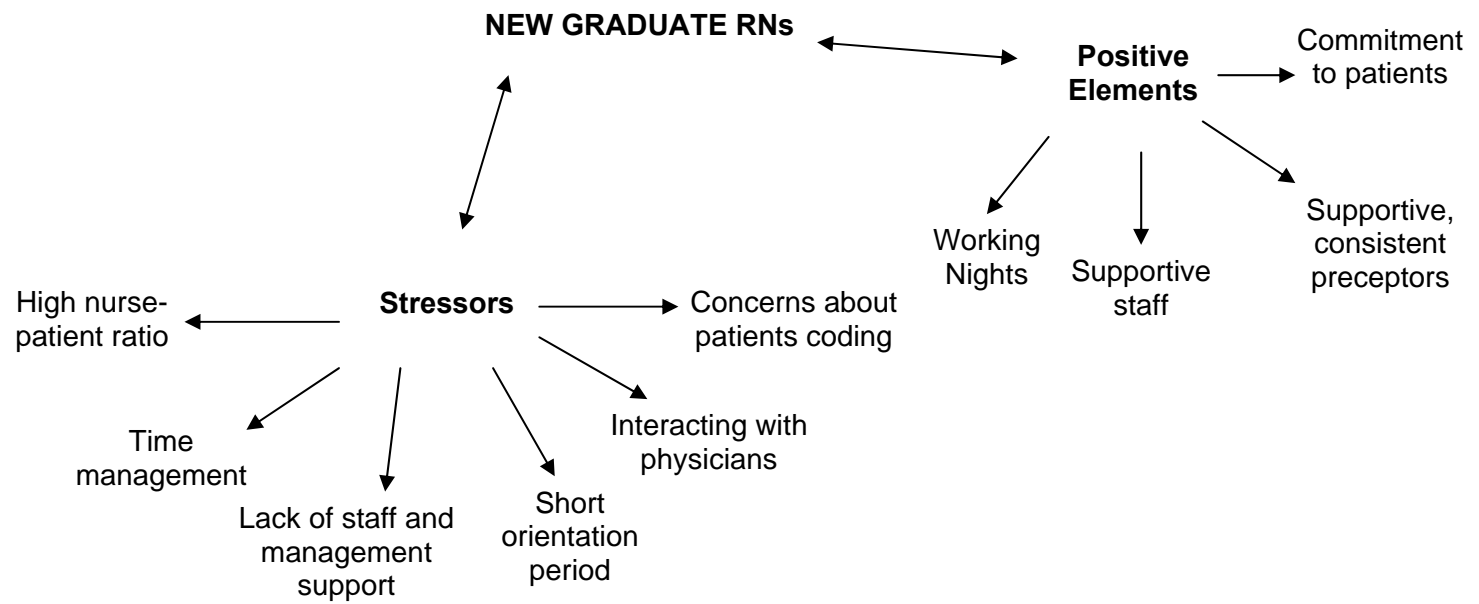


Figure 8.
Summary of all experiences of new graduate baccalaureate RNs working in an acute care hospital setting.

CHAPTER 5

DISCUSSION

This chapter presents the discussion of research findings, and will summarize themes that were ultimately rendered. In addition, recommendations will be generated based on the findings from the study. Recommendations for future research will also be presented.

The purpose of this phenomenological study was to explore the lived experience of new graduate baccalaureate-prepared Registered Nurses who work in an acute care hospital setting. Eight RNs were interviewed by me in a quiet, private environment. Each participant signed the consent, and agreed for the interviews to be audiotaped. Seven of the interviews were usable. I transcribed all of the interviews verbatim, and analyzed the data using a modified version of the Stevick-Colaizzi-Keen Method that was described by Moustakas (1994). Hours of data were rendered from which I reflected, reviewed, and identified themes that were common among all participants. Textural and structural descriptions were used to support the findings. I also considered my own experience, and provided a textural-structural description of my own. A copy of the interview was provided to each participant to conduct a member check, which strengthened and validated the findings. In addition, the interviews were read by three other individuals in order to ensure that findings were consistent with mine. The reviewers were an RN educator who teaches in a baccalaureate nursing program, a nurse practitioner who has extensive experience in nursing education, and my major professor. This was a critical step that served to

enhance the audibility and credibility. Throughout the research process, detailed field notes were maintained. The field notes provided an invaluable method that I could record my own thoughts, observations, and feelings about the interviews.

What started out as a research study on a topic that was of extreme interest to me, soon became an unforgettable experience that was meaningful and significant to both myself and the participants. I was often amazed by the honesty of the new RNs, and how they hoped that their stories would help others. I was consistently impressed by the dedication to nursing and their patients, and I could sense their frustrations and triumphs as they expressed their thoughts. In this chapter, I will present and discuss the findings that evolved throughout the research process. Recommendations will be provided, and suggestions for further research will be presented.

Honeymoon Phase

The initial feelings and experiences of the new RNs were consistent among all participants. All of the new RNs were excited and anxious to begin their jobs, and looked forward to learning their roles. The RNs were beginning a new chapter in their lives, and were going to be practicing independently after several grueling years in the student role in a baccalaureate nursing program. This was their “honeymoon phase” that began what would hopefully become a lifetime commitment to the nursing profession. Although they were nervous about what to expect as they began work, the RNs were eager to contribute to the nursing profession. Nursing is both an art and a science, and the RNs wanted to help their patients by using their strong educational background to provide

excellent nursing care. However, too-short orientation periods and high nurse-patient ratios quickly transformed their previous excitement into harsh reality.

Overwhelmingly, the RNs discussed their frustrations about trying to balance patient care with the other demands of nursing. They described their commitment to patient care, but their disillusionment of not having the time they felt was necessary to serve as a patient advocate and educator. Many of the RNs felt that the time spent in orientation was too short, and they believed that they were not ready to practice independently with a demanding high nurse-patient ratio. While the RNs felt that time spent in orientation working with the charge nurse and unit clerk was important, they did not want that time to interfere with much needed time with their preceptor.

The preceptor served as an integral component to the success or detriment to the RNs. A good preceptor was a role model, mentor, support system, and teacher. This invaluable resource was often not scheduled to work with the RN after orientation. Each participant believed that continuing to work with their preceptor might have assisted in the transition. A good preceptor in the honeymoon phase was critical, because it set the tone for the work environment.

Transition Phase

Soon after the participants completed orientation, they were often overwhelmed by the reality of their jobs. The honeymoon was coming to an end far too soon, and the “transition phase” into independent practice was harder than most anticipated. All of the RNs recognized and acknowledged that nursing is hard work. However, many were surprised by the mental and physical

stressors, and often would leave the hospital exhausted at the end of the day. During this transition, several of the new RNs stated that they would cry with frustration, but continued to work because they felt a commitment to their patients and had to keep going.

The stressors that were consistently identified were the short orientation periods, high nurse-patient ratios, and time management issues. Every participant believed that a nurse-patient ratio of one to five would be more manageable and safe. They also had concerns about interacting with physicians, which may have been helped by longer orientation periods. While the participants were committed to providing excellent care, this was often hindered by not having the time to conduct thorough assessments and follow-up checks on the patients.

Of great concern was the lack of support by other staff nurses. While some of the RNs stated that the staff was overall excellent, many of them reported that they were very selective with whom they would solicit help. In addition, some of the RNs felt like a burden if they asked too many questions. However, they asked the questions or validated their assessments prior to making nursing decisions to ensure patient safety. The commitment to excellent patient care was apparent in all of the RNs. However, as they transitioned into their new role a major frustration voiced was the lack of extra time that they had to merely interact with patients.

During the transition phase, the RNs were becoming acclimated not only to their new role, but also to the hospital and unit environment. Many of the RNs

described frustration with the overall unit layout and logistics of patient rooms to the nurses' station. They considered walking the long halls to get basic equipment a frustration because it took away from patient care. However, this also contributed to their time management issues, which every new RN described as a problem.

Always in the back of their mind was the concern that one of their patients condition would grossly deteriorate and subsequently code and die. Of greater concern was the idea that the new RN would not recognize assessment changes in their patients, and would not intervene in a timely manner. However, every RN felt that the unit support was excellent when help was needed in a crisis situation. This supports the commitment to patient care among the majority of nurses, and role models to the new RNs how to react in a stressful situation.

Working the night shift seemed to be of value during the transition period. The RNs stated that fewer physicians and managers on the unit made their jobs somewhat more manageable. Furthermore, some worked nights to help with their time management and become more comfortable in their roles. Those who did not work nights recognized the value of working that shift as new RNs.

Many of the acute care units had nurses with limited experience. Michael selected the unit in which he works because he recognized an experienced staff. He said that this was of great value in his honeymoon and transition phases, and works nights because of his co-workers. In addition, Michael intends to stay on the unit past a year because of this working environment. This supports the importance of mentoring the new RNs so that an experienced staff would be

available to the new nurses. One cannot teach experience, but new RNs learn a tremendous amount of new knowledge, increase confidence, and perfect skills by working with supportive professional co-workers.

The end of the transition phase is marked by a comfort level that the RNs begin to experience. The idea that they are “the nurse” providing care for the patient becomes a reality, and ultimately their confidence begins to increase. As this happens, however, the RNs begin to examine their work situation, and make a critical decision in the future of their job. At this point, usually within a year of employment, the RNs make the decision to divorce from a stressful situation or reconcile.

Divorce or Reconciliation Phase

The participants were overall dissatisfied and disillusioned with their jobs. Many of them intend to leave their jobs, with one already having a new position in home health. The participants either plan to divorce themselves from their job, or reconcile. Those who have reconciled were somewhat surprised that they planned to stay. The general idea that the participants had was to use an acute care hospital setting as a stepping stone to gain experience and seek employment in other specialty areas.

Those that left cited several reasons. The high nurse-patient ratio was overwhelming, and working in a specialty unit such as ICU or Labor and Delivery would not require such demands. Unsupportive co-workers and managers also made their job stressors increase dramatically, and those who stayed were happy with their overall working environment. Because nursing is a stressful

profession, a supportive nursing and management staff is critical to the success of the new RN. Table 1 summarizes the phases experienced by new the new graduate RNs.

Table 1
Identified Phases of the New RNs Experience Working in an Acute Care Hospital Setting

Honeymoon Phase	Transition Phase	Divorce or Reconciliation Phase
Excited	Orientation too short	Staff Support
Nervous to anxious	Lack of staff support	Desire to go to specialty unit
Effective preceptors	Inconsistencies with preceptors	
Orientation experience	Concerns about code situations	Continue education
	Time management	1-Year experience
	Nurse-patient ratio too high	Increase in confidence levels
	Lack of management support	
	Interacting with physicians	

Recommendations

The need to keep baccalaureate-prepared RNs in the acute care hospital setting is tremendous. The high acuity of patients in the hospital requires that RNs have extensive theory and clinical education that provides a knowledge base necessary for safe care. This is supported in the literature by Aiken, Clarke, Cheung, Sloane and Silber (2003), who identified a clear link between higher levels of nursing education and better patient outcomes. The study found that surgical patients have a “substantial survival advantage” if treated in hospitals with higher proportions of nurses educated at the baccalaureate or higher degree

level. Given the magnitude of this need for baccalaureate-prepared RNs, hospitals should make every effort to recruit and support these nurses. In addition, once they are hired, retention is critical. In this study, findings evolved that may be of value to nurse managers, staff nurses, and hospital administrators. In addition, findings from this study were consistent with a phenomenological qualitative study conducted by Boychuk-Duchscher (2001), which investigated newly graduated nurses in the acute care hospital setting. Boychuk-Duchscher (2001) identified three major themes that evolved from interviews that were conducted. Theme one, "Doing Nursing," included many experiences that the new graduates experienced, such as dependency on others, fear of physicians, self-absorption, leaving the nest, the unwelcome wagon and focus on doing. Theme two was described as "The Meaning of Nursing," where some intense feelings from the graduates were experienced. The participants were emotionally, spiritually, and physically exhausted, and were growing weary of the dichotomies between what was learned in school and the realities of practice. They were also searching for more stability and in their professional role expectations, and were accepting their inadequacies and imperfections. Theme three, "Being a Nurse," evolved approximately five months into their practice as a RN, when a sense of self-determination was gained. Such ideas as puppet off a string, critical thinking, and professional maturation were described. The findings identified by Boychuk-Duchscher (2001) are consistent with the conclusions from this study, and further support the importance of preceptors and a positive work environment.

Findings from this study are also supported by Charnley (1999), who conducted a grounded theory qualitative study. Charnley (1999) investigated occupational stress in the newly qualified staff nurse during the first six months as practitioners. Four major categories were identified. Category one, the reality of practice, found that almost all participants experienced feelings of stress in their new roles and status. Feelings of anxiety relating to the sheer volume of work were expressed, and feelings of guilt and resentment were described. Furthermore, staff shortages contributed to the stress, because learning in practice is dependent of the availability and time of other staff. Category two, learning the system, also identified much anxiety by the participants. Learning the environment was one concern expressed, as well as time management and prioritizing. Category three, developing clinical judgment, noted that many of the participants did not possess the confidence to deal with the rigors of practice. The knowledge base was present, but the experience was not. Category four, developing professional relationships, again identified anxiety as a problem. Concerns about supervising health care assistants and being accountable for their actions were expressed. In addition, poor communication and lack of support among staff were described. In this study, staff support was critical to the new graduate RNs. Those who perceived staff support were much more likely to remain working in the acute care hospital setting.

Longer Orientation Periods

All of the nurses who participated in this study felt that their orientation period was too short. Most were out of orientation in less than eight weeks, and

many were pulled out of orientation earlier. The nursing shortage has created a need for the nurses to begin to practice independently as a staff nurse. However, findings from this study suggest that a longer orientation would increase the confidence of the new RN, and provide them with essential support that helps them transition. A longer orientation period of at least three months would assist them in perfecting time management and prioritizing, while having a preceptor to provide feedback and role model effective behaviors. These findings are supported by Oerman and Moffitt-Wolf (1997), who sought to describe the stresses and challenges experienced by graduate nurses in clinical practice during the time of their initial orientation period to the hospital setting. Oerman and Moffitt-Wolf (1997) found that stressors such as lack of experience, interactions with physician, lack of organizational skills, and new situations and procedures were cited by new nurses during the orientation period. In addition, there were significant positive correlations between social support and stimulation in clinical practice and development of confidence in practice. Other stressors identified in the study were time limitations in orientation, frequent distractions, staff criticism, questioning from staff, feelings of anxiety and overwhelmed, and lacking needed guidance from preceptors. However, graduates who had a consistent preceptor had a more positive experience while in orientation. These conclusions are consistent with findings from this study, and overwhelming support the need for a positive orientation experience with an excellent, consistent preceptor.

While the RNs wanted to learn the computer, charge nurse roles, and attend other orientation classes, they felt that this was critical time away from learning patient care. Therefore, it is recommended that the new RN participate in these activities, but not have it considered orientation time at the bedside providing patient care. This time could be offered prior to starting on the floor, or select days during the orientation period.

Many concerns were expressed by the new RNs about patients coding and not recognizing a change in patient status. Longer orientation periods would allow the nurse to work with their preceptor and gain confidence in decision making about a variety of patient care situations. In addition, this would allow the new RN to participate in code situations with other nurses on the unit. The participants in this study all learned from watching others in emergent situations. In addition, the extra time would give the new RN an opportunity to gain comfort interacting with physicians, which was cited as a common stressor.

Nurse managers might consider making working nights at least part of the orientation period. The RNs that worked the night shift found that environment to be conducive to the transition phase. If the RN works days, then select shifts may be assigned so that the new RN can become familiar with the pace and routine of nights.

Preceptors

The preceptor played a significant role in the success of the new RN. This sets the tone for the RN, and those that had a good preceptor were overall more satisfied with their jobs. Those that did not have a good preceptor became

frustrated quicker and subsequently left their job. Preceptors should be able to role model excellent nursing care, and be appropriately prepared to assume the responsibility. Hospital education departments should offer preceptor courses, and ensure that those who are selected to serve as preceptors have available support and evaluation. Managers who select preceptors should be cognizant of the qualities of a good preceptor, and be confident that the nurse wants to serve in that role.

Although it is not always possible, every effort should be made to keep the new RN and preceptor working the same schedule. In addition, consistency with a preceptor was very important to the new RN. However, if the preceptor and the new RN are not compatible, the nurse manager should assign a new preceptor better suited to meet the RNs needs. These recommendations are supported in the literature by

Nurse-Patient Ratio

All of the participants in the study found the nurse-patient ratio to be too high. Many were responsible for seven to eight patients, which they found to be overwhelming. Although they were able to provide the care to their patients, the new RNs were very frustrated because they did not feel there was enough time to spend with them. Great concerns were expressed about the safety of high nurse-patient ratios, and served as an impetus for many of the RNs to leave the acute care unit. It is unreasonable to expect the new RN to care for the same number of patients that an experienced nurse is able to provide. Therefore, it is recommended that the nurse patient ratio be no more than one to five. The RNs

participating in this study all felt that five patients would allow them to provide safe, competent care. In addition, this would help in the reconciliation to stay on the unit.

Because hospital budgets are a reality, many hospitals are hesitant to decrease the nurse-patient ratio. However, the research supports that lower nurse-patient ratios provide safer care with higher patient satisfaction. In addition, because the cost of orientating new nurses is considerable, the retention of these nurses might off-set that cost. Ultimately, the hospital may save money, and patients would be more willing to seek services from a facility that offers excellent nursing care.

Support for New RNs

The new RNs often felt like they had no one with whom they could safely share their concerns. Busy managers, charge nurses, and co-workers simply did not have the time to “just listen” to the new RN. Although the preceptor was there for support, that time was devoted to acclimating to the caregiver role. A grounded theory qualitative study conducted by Brighid (1998) also emphasized the importance of social forces in the maintenance of professional values and of a valued professional identity. Disparity from what the new nurses expect from themselves and what they actually experience in practice can predispose them to moral distress. Hospital and nurse managers need to be aware that lack of support leads to psychosocial stress and decreased job satisfaction. In addition, a study conducted by Shader et al. (2001) found that work satisfaction, weekend overtime, job stress, and group cohesion were all predictors of the anticipated

turnover rate. Therefore, it is recommended that hospitals consider having an individual who serves as a “support” person for the new RN hires. This person does not have to be limited to new graduate RNs, but to all new nurses who are hired at to work at the facility. However, the new RNs could meet with this person, or even have support groups with other new nurses where concerns can be shared and support offered to each other. This may contribute to job satisfaction, and ultimately retain nurses in acute care hospital settings.

Fisher et al. (1994) conducted a study that examined selected predictors of RNs intent to stay on the job. Although the study did not focus on new graduate RNs, the participants had at least 11 years of experience and had held at least two previous jobs. However, many of these nurses had moved within the facility. Fisher et al. (1994) support findings from this study because it noted that retention of staff within the institution may be less costly than having to replace nurses who leave.

Suggestions for Future Research

Findings from this study generated several ideas for future research relating to new graduate RNs. Because many participants felt that their nurse managers were not readily available, qualitative research could be conducted with nurse managers to gain insight into their roles. More research is needed to determine patient satisfaction in acute care hospital settings where RNs are the primary caregivers. Further comparative studies could be conducted in institutions that primarily use Licensed Practical Nurses (LPNs) to provide bedside care versus RNs. This could be conducted in terms of patient outcomes

and patient satisfaction. Longitudinal studies could be conducted examining the satisfaction of RNs who remain in acute care hospital settings for a period of time, such as greater than two years.

Studies could also be conducted that compare perceived stressors from RNs working in specialty areas such as ICU or recovery room to those who work in acute care hospital settings. This research could determine if differences exist among these nurses relating to stressors and the intent to leave or remain employed by the hospital. In addition, schools of nursing could conduct follow up studies from graduates after six months to one year of practice to determine if curricula could be modified to assist with the transition from new student to RN. These studies could be conducted from a qualitative or quantitative perspective, and would assist nursing faculty in better meeting the needs of the students.

REFERENCES

- Aiken, L., Clarke, S., Cheung, R., Sloane, D., & Silber, J. (2003). Education levels of hospital nurses and patient mortality. *Journal of the American Medical Association*, 290, 1617-1623.
- Ames, A., Adkins, S., Rutledge, D., Hughart, K., Greeno, S., Foss, J., et al. (1992). Assessing work retention issues. *Journal of Nursing Administration*, 22(4), 37-41.
- Blegen, M. (1993). Nurses' job satisfaction: A meta-analysis of related variables. *Nursing Research*, 42(1), 36-41.
- Boychuk-Duchscher, J. (2001). Out in the real world: Newly graduated nurses in acute-care speak out. *Journal of Nursing Administration*, 31(9), 426-439.
- Brighid, K. (1998). Preserving moral integrity: "A follow-up study with new graduate nurses. *Journal of Advanced Nursing*, 28(5), 1134-1145.
- Brink, P. (1991). Issues of reliability and validity. In J. Morse (Ed.), *Qualitative nursing research: A contemporary dialogue*. (pp. 164-186). Newbury Park, CA: Sage Publications.
- Brown, H. & Edelmann, R. (1999). Project 2000: A study of expected and experienced stressors and support reported by students and qualified nurses. *Journal of Advanced Nursing*, 31(4), 857-864.
- Buerhaus, P. (2002) Shortages of hospital registered nurses: Causes and perspectives on public and private sector actions. *Nursing Outlook*, 50(1), 4-6.
- Charnley, E. (1999). Occupational stress in the newly qualified staff nurse. *Nursing Standard*, 13(29), 33-36.
- Chenitz, W. & Swanson, J. (1986). Qualitative research using in grounded theory. In W. Chenitz, & J. Swanson (Eds.), *From practice to grounded theory* (pp. 3-15). Menlo Park, CA: Addison-Wesley.
- Cohen, S., Kamarck, T., & Mermelstein, R. (1983). A global measure of perceived stress. *Journal of Health and Social Behavior*, 24, 385-396.
- Contino, D. (2002). How to slash costly turnover. *Nursing Management*, 33(2), 10-13.
- Denzin, N.K. (1978). *The Research Act: A Theoretical Introduction to Sociological Methods*. New York: McGraw-Hill.

- Domrose, C. (2002). A guiding hand--experienced RNs say new nurses deserve capable mentors to help ease the transition in to the workplace. *Nurse Week*, February 18, 2002.
- Duncan, K. (1997). Student pre-entry experience and first year of employment. *The Journal of Continuing Education in Nursing*, 28(5), 223-230.
- Eisner, E.W. (1991). *The Enlightened Eye. Qualitative Inquiry and the Enhancement of Educational Practice*. New York: Macmillan Publishing Company.
- Fisher, M., Hinson, N., & Deets, C. (1994). Selected predictors of registered nurses' intent to stay. *Journal of Advanced Nursing*, 20, 950-957.
- Fletcher, C.E. (2001). Hospital RNs' job satisfactions and dissatisfactions. *Journal of Nursing Administration*, 31(6), 324-331.
- Gardner, D.L. (1992). Conflict and retention of new graduate nurses. *Western Journal of Nursing Research*, 14(1), 76-85.
- Graham, J. (1982). *Exit and voice: the prediction of political behavior by nurses engaged in hospital practice*. Unpublished doctoral dissertation, Indiana University School of Nursing, Indianapolis, Indiana.
- Graham, T. (2002). What nurses say. *Nurse Week*, April 15, 2002.
- Heslop, L, McIntyre, M, & Ives, G. (2001). Undergraduate student nurses' expectations and their self-reported preparedness for the for the graduate year role. *Journal of Advanced Nursing*. 36(5), 626-634.
- Hinds, P., Sanders, C., Srivastave, D., Hickey, S., Jayawardene, D., Milligan, M., et al. (1998). Testing the stress-response sequence model in paediatric oncology nursing. *Journal of Advanced Nursing*, 28(5), 1146-1157.
- Hinshaw, A., Smeltzer, C., & Atwood, J. (1987). Innovative retention strategies for nursing staff. *Journal of Nursing Administration*, 17, 8-16.
- Hutchinson S. (1986). Grounded theory: the method. In Munhall P.C. & Oiler C.J. (Eds.), *Nursing Research – A Qualitative Perspective*. Norwalk, Connecticut: Appleton Century Crofts.
- Kimchi, J., Polivka, B., & Stevenson, J. (1991). Triangulation: Operational definitions. *Nursing Research*, 40(6), 364-366.

- Kramer, M. (1974). *Reality shock: Why nurses leave nursing*. St. Louis: Mosby.
- Lipson, J. (1991). The use of self in ethnographic research. In J. Morse (Ed.), *Qualitative nursing research: A contemporary: dialogue* (pp. 73-89). Newbury Park, CA: Sage Publications.
- Louisiana State Board of Nursing (2002). *Analysis by field of employment*. January 31, 2002. Louisiana State Board of Nursing.
- McKee, V. (1994). Does orientation affect retention? *Journal of Nursing Staff Development*, 10(2), 97-98.
- Marshall, C. & Rossman, G.B. (1999). *Designing qualitative research* (3rd ed.). Thousand Oaks, CA: Sage Publications.
- Mills, A., & Blaesing, S. (2000). A lesson from the last nursing shortage-the influence of work values on career satisfaction with nursing. *Journal of Nursing Administration*. 30(6), 309-315.
- Munhall, P. (2001). *Nursing research, a qualitative perspective*. Sudbury, MA: Jones and Bartlett Publishers.
- Moustakas, C. (1994). *Phenomenological Research Methods*. Thousand Oaks, CA: Sage Publications.
- Nayak, S. (1991). Strategies to support the new nurse in practice. *Journal of Staff Development*, 7, 64-66.
- Norwood, S. (2000). *Research Strategies for Advanced Practice Nurses*. Upper Saddle River, NJ: Prentice Hall Health.
- Oermann, M.A. & Moffitt-Wolf, A. (1997). New graduates' perceptions of clinical practice. *The Journal of Continuing Education in Nursing*, 28(1), 20-24.
- Olson, R., Nelson, M., Stuart, C. Young, L., Kleinsasser, A., Schroedermeier, R. et al. (2001). Nursing student residency program: A model for a seamless transition from nursing student to RN. *The Journal of Nursing Administration*, 31(1), 40-48.
- Owens, D., Turjanica, M., Scanion, M., Sandhusen, A., Williamson, M., Hebert, C., et al. (2001). New graduate RN internship program: A collaborative approach for system-wide integration. *Journal for Nurses in Staff Development*, 17(3). 144-150.
- Pagana, K.D. (1989). Psychometric evaluation of the clinical stress questionnaire. *Journal of Nursing Education*, 27, 418-424.

- Parse, R. (1996). Building knowledge through qualitative research: the road less traveled. *Nursing Science Quarterly*, 9(1), 10-16.
- Patton, M. (1990). *Qualitative Analysis and Research Methods*. (2nd ed.). Newbury Park, CA: Sage Publications.
- Patton, M. (2002). *Qualitative Evaluation and Research Methods* (3rd ed.). Thousand Oaks, CA: Sage Publications.
- Rossmann, G. and Rallis, S. (2003). *Learning in the Field*. Thousand Oaks: Sage Publications.
- Sampson, H. (2004). Navigating the waves: the usefulness of a pilot in qualitative research. *Qualitative Research*, 4(3), 383-402.
- Sandelowski, M. (1986). The problem of rigor in qualitative research. *Advances in Nursing Research*, 40(3), 27-37.
- Shader, K., Broome, M., Broome, C., West, M., & Nash, M. (2001). Factors influencing satisfaction and anticipated turnover for nurses in an academic medical center. *Journal of Nursing Administration*, 31(4), 210-216.
- Strauss, A. L. (1987). *Qualitative analysis for social scientists*. New York: Cambridge University Press.
- Tomey, A., Bakas, T. & Deets, C. (1990). *Development of an instrument to measure managerial environment*. Unpublished manuscript. Indiana University, Indianapolis, IN.
- Van Manen, M. (1990). *Researching lived experience: Human science for an action sensitive pedagogy*. Albany: SUNY Press.
- Velianoff, G. (1986). *A construct validity study: accountability for nursing care*. Unpublished doctoral dissertation. Indiana University School of Nursing. Indianapolis, IN.
- Venes, D. (Ed.). (2001). *Taber's Cyclopedic Medical Dictionary*. (18th ed.). Philadelphia: F.A. Davis Company.
- Winter-Collins, A. & McDaniel, A.M. (2000). Sense of belonging and new graduate job satisfaction. *Journal for Nurses in Staff Development*. 16(3), 103-111.

Yoder, L.H. (1995). Staff nurses' career development relationships and self-reports of professionalism, job satisfaction, and intent to stay. *Nursing Research*, 44(5), 290-297.

APPENDIX A

APPROVED INSTITUTIONAL REVIEW BOARD APPLICATION

IRB #: 2712 LSU Proposal #: _____ Revised: 5/24/2004
LSU INSTITUTIONAL REVIEW BOARD (IRB) for 578-8692 FAX 6792
HUMAN RESEARCH SUBJECT PROTECTION Office: 203 B-1 David Boyd Hall
Study exempted by
Louisiana State University
Institutional Review Board
203 B-1 David Boyd Hall
225-578-8692

Unless they are qualified as meeting the specific criteria for exemption from Institutional Review Board (IRB) oversight, ALL LSU research/human subjects, or samples or data obtained from humans, directly or indirectly, with or without their consent, must be approved or exempted in advance by the LSU IRB. This Form helps the PI determine if a project may be exempted, and is used to request an exemption

Instructions: Complete this form.

Exemption Applicant: If it appears that your study qualifies for exemption send:

- (A) Two copies of this completed form,
- (B) a brief project description (adequate to evaluate risks to subjects and to explain your responses to Parts A & B),
- (C) copies of all instruments to be used. If this proposal is part of a grant proposal include a copy of the proposal and all recruitment material.
- (D) the consent form that you will use in the study

One screening committee member (listed at the end of this form) in the most closely related department/discipline or to IRB office.

If exemption seems likely, submit it. If not, submit regular IRB application. Help is available from Dr. Robert Mathews, 578-8692, rb@lsu.edu or any screening committee member.

Principal Investigator Jeannie Harper, MSN, RN Student? Yes

Phone: 225-272-2596 E-mail jharpe3@lsu.edu
Dept/Unit: School of Human Resource Education and Workforce Development
Old Forestry Bldg. Room 142

If Student, name supervising professor Dr. Krisanna Machtmes Ph: 578-844

Mailing Address

Project Title: A Phenomenological Study of the Lived Experience of New Graduate Baccalaureate Registered Nurses Working in Acute Care Hospital Settings

Agency expected to fund project None

Subject pool (e.g. Psychology Students) Registered nurses

Circle any "vulnerable populations" to be used: (children <18; the mentally impaired, pregnant women, the aged, other). Projects with incarcerated persons cannot be exempted.

I certify my responses are accurate and complete. If the project scope or design is later changed I will resubmit for review. I will obtain written approval from the Authorized Representative of all non-LSU institutions in which the study is conducted.

[Signature Jeannie Harper Date 6-2-04 (no per signatures)

IRB Committee Action: Exempted ☒ Not Exempted ☐ Category/Paragraph _____

Reviewer Ridwan Naw Signature [Signature] Date 3 June 2017

Part A: DETERMINATION OF "RESEARCH" and POTENTIAL FOR RISK

This section determines whether the project meets the Department of Health and Human Services definition of "research" and if not, whether it nevertheless presents more than "minimal risk" to humans that makes IRB review prudent and necessary.

1. Is the project a systematic investigation designed to develop or contribute to generalizeable knowledge?

(Note "systematic investigation" includes "research development, testing and evaluation"; therefore some instructional development and service programs will include a "research" component).

☒ YES

☐ NO

2. Does the project present physical, psychological, social or legal risks to the participants reasonably expected to exceed those risks normally experienced in daily life or in routine diagnostic physical or psychological examination or testing? You must consider the consequences if individual data inadvertently become public.

☐ YES Stop. This research cannot be exempted--submit application for IRB review.

☒ NO Continue to see if research can be exempted from IRB oversight

3. Are any of your participants incarcerated?

☐ YES Stop. This research cannot be exempted--submit application for IRB review.

☒ NO Continue to see if research can be exempted from IRB oversight.

Part B: EXEMPTION CRITERIA FOR RESEARCH PROJECTS

Research is exemptable when all research methods are one or more of the following five categories. Check statements that apply to your study:

☐ 1. In education setting, research to evaluate normal educational practices.

-
- ☒ 2. For research not involving vulnerable people [prisoner, fetus, pregnancy, children, or mentally impaired]: observe public behavior (including participatory observation), or do interviews or surveys or educational tests:

The research must also comply with one of the following:

either that

- ☐ a) the participants cannot be identified, directly or statistically;

or that

- ☒ b) the responses/observations could not harm participants if made public;

or that

- ☐ c) federal statute(s) completely protect all participants' confidentiality;

or that

- ☐ 3. For research not involving vulnerable people [prisoner, fetus, pregnancy, children, or mentally impaired]: observe public behavior (including participatory observation), or do interviews or surveys or educational tests:
- all respondents are elected, appointed, or candidates for public officials.

-
- ☐ 4. Uses only existing data, documents, records, or specimens properly obtained.

The research must also comply with one of the following:

either that:

- ☐ a) subjects cannot be identified in the research data directly or statistically, and no-one can trace back from research data to identify a participant;

or that

- ☐ b) the sources are publicly available

-
- ☐ 5. Research or demonstration service/care programs, e.g.

APPENDIX B

INFORMATION LETTER TO PARTICIPANTS

Dear Registered Nurse,

The reality of a nursing shortage is clear as you deliver care in the acute care hospital setting. Increases in patient acuity coupled with short staffing require that registered nurses (RNs) be available to provide the excellent nursing care that patients deserve. Registered Nurses who have graduated from baccalaureate nursing programs have the theoretical foundation and knowledge base that is necessary to provide safe and effective nursing care. It is imperative that acute care hospitals are able to retain registered nurses to deliver this excellent nursing care. Unfortunately, the average length of stay baccalaureate RNs remain employed in hospital settings is less than one year. This short time that RNs remain employed in acute care hospital settings limits the number of experienced nurses available to assist the new RNs. Furthermore, it can cause extra stressors to the experienced RNs because they are needed as resources and have limited time to mentor the new graduate nurses. It is critical that nurse managers and hospital administrators become aware of the reasons that RNs choose to leave the hospital. I am conducting a qualitative phenomenological study to explore the lived experience of new graduate baccalaureate registered nurses who work in acute care hospital settings. This study will consist of interviews with the researcher to determine what has been effective or stressful in the role of a new RN. The findings of this study will assist nurse managers and hospital administrators in retaining RNs, thus ensure excellent bedside nursing care.

Participation in this study is voluntary and you may withdraw at any time. Although there will be no immediate benefits to you for participating in this study, the findings could provide essential information about new graduate nurses that could help others as they acclimate to their new RN position. In addition, there are no known risks for participating in the study. The interview process will be completely confidential, and transcription will be done by the researcher and not shared with anyone else except the major professor. You will be assigned a "false" name for transcription and data analysis purposes. All tapes and transcriptions will be locked in the in the researcher's office until the study is completed and then they will be shredded.

There will be one demographic form to complete which will take approximately five minutes of your time. A consent form is also enclosed, and must be signed by yourself and the researcher. Please keep a copy for yourself and the researcher will keep a signed copy. Please feel free to contact me at (225) 272-2596 or (225) 765-2324 or Dr. Krisanna Machtmes at (225) 578- 5748 for any questions or concerns you may have about the study.

The results from this study will be available December 2005. If you would like information about the results, please contact me at the above numbers. Thank you for your participation in this study.

Sincerely,

Jeannie R. Harper, MSN, RN
Doctoral Student
Louisiana State University School of Human Resource Education and Workforce Development

APPENDIX C
CONSENT FORM

Participant Consent Form

Title of Study: A Phenomenological Study of the Lived Experience of New Graduate Baccalaureate Registered Nurses Who Work in Acute Care Hospital Settings.

Principle Investigator: Jeannie Harper, MSN, RN
Doctoral Student
LSU School of Human Resource Education and
Workforce Development
Phone: (225) 765-2324 or (225) 272-2596
Email: jharpe3@lsu.edu

Supervising Professor Krisanna Machtmes, Ph.D
Assistant Professor
LSU School of Human Resource Education and
Workforce Development
Phone (225) 578-
Email: kmachtme@lsu.edu

Purpose of Research: The primary purpose of this study is to explore the lived experience of new graduate Registered Nurses working in an acute care hospital setting within the first year of practice as perceived by recent graduates of baccalaureate nursing programs employed in an acute care hospital setting in Louisiana.

Risks: It is not anticipated that you will experience any risks for participating in the study.

Benefits: There are no immediate benefits to participating in this study. However, results from this study could be beneficial in assisting other new graduate RNs acclimate to their new job. In addition, findings from this study could assist nurse managers and hospital administrators make changes to assist in retention of new RNs.

Confidentiality of Responses: The interviews will be conducted only by the student researcher and shared with the primary researcher. A "false" name will be applied to you to ensure your confidentiality in transcription.

Right to Withdraw or Refuse to Participate: Your participation in this study is completely voluntary. You may refuse to participate in the study or withdraw from the study at any time.

Questions or concerns should be addressed to the Principle Investigator, Jeannie Harper at (225) 272-2596 or Major Professor, Dr. Krisanna Machtmes at (225) 578-5748.

The study has been discussed with me and all my questions have been answered. I may direct additional questions regarding study specifics to the investigators. If I have questions about subjects' rights or other concerns, I can contact Robert C. Mathews, Chairman, LSU Institutional Review Board, (225) 578-8692. I agree to participate in the study described above and acknowledge the researchers' obligation to provide me with a copy of this consent form if signed by me.

Signature _____ Date _____

VITA

Jeannie Harper was born Jeannie Elaine Ricks on May 24, 1962, in Baton Rouge, Louisiana. Her parents are Joseph and Esther Ricks. She attended Belaire High School, and graduated in 1980. She began her post-secondary education at Southeastern Louisiana University, where she graduated with a Bachelor of Science degree in nursing in 1985. Jeannie is married to Hal Harper, and together they have two children, Bryan and Rachel.

Jeannie worked as a staff nurse in maternal nursing for seven years, with special interest in high-risk maternity and women's health. She was certified by the National Certification Corporation for Obstetric, Gynecologic, and Neonatal Nursing Specialties in Ambulatory Women's Health Care Nursing in 1992. It was during that time that Jeannie recognized the need to continue her education, and she earned her Master of Science in nursing degree in psychosocial nursing from Southeastern Louisiana University in 1994, and began teaching at Baton Rouge General School of Nursing. Her master's thesis was entitled "Psychosocial Stressors and Coping Mechanisms of Infertile Women and Women with One Biological Child." Jeannie began pursuing her doctorate in 2000 from Louisiana State University, and the degree of Doctor of Philosophy will be conferred during the fall commencement ceremony on December 16, 2005.

Jeannie has worked in a variety of areas, including post anesthesia nursing and critical care. She has been teaching at Southeastern Louisiana University School of Nursing since 2000, and presently teaches adult health and

mental health clinical and theory. She also works as an Inpatient Case Manager at the Baton Rouge General Medical Center per diem.

Jeannie has had the opportunity to be a poster presenter at a variety of local and state conferences. She has developed and implemented in-services for nurse managers on such topics as delegation, communication, and conflict.

Jeannie has also reviewed test questions for Ambulatory Women's Health Care Nursing certification exam.

Jeannie is a member of the Rho Zeta Chapter of Sigma Theta Tau International Honor Society of Nursing, where she has served on the board as Counselor. She enjoys working in the community in health fairs, and has been very active in her children's schools. Presently, she resides with her family in Baton Rouge, Louisiana.